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U.S. Congress. Senate. Committee on Labor and Public Welfare. Subcommittee on Health
Heart disease, cancer, stroke, and kidney disease amendments of 1970.

HEART DISEASE, CANCER, STROKE, AND KIDNEY DISEASE AMENDMENTS OF 1970

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

1. S SENATE, SENATE

COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 3355

TO AMEND TITLE IX OF THE PUBLIC HEALTH SERVICE ACT SO AS TO EXTEND AND IMPROVE THE EXISTING PROGRAM RELATING TO EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, STROKE, AND OTHER MAJOR DISEASES AND CONDITIONS, AND FOR OTHER PURPOSES

S. 3443

TO AMEND AND IMPROVE THE PUBLIC HEALTH SERVICE ACT TO AID IN THE DEVELOPMENT OF INTEGRATED, EFFECTIVE, CONSUMER-ORIENTED HEALTH CARE SYSTEMS BY EXTENDING AND IMPROVING REGIONAL MEDICAL PROGRAMS, SUPPORTING COMPREHENSIVE PLANNING OF PUBLIC HEALTH SERVICES AND HEALTH SERVICES DEVELOPMENT ON A STATE AND AREAWIDE LEVEL, PROMOTING RESEARCH AND DEMONSTRATIONS RELATING TO HEALTH CARE DELIVERY, ENCOURAGING EXPERIMENTATION IN THE DEVELOPMENT OF COOPERATIVE LOCAL, STATE, OR REGIONAL HEALTH CARE DELIVERY SYSTEMS, ENLARGING THE SCOPE OF THE NATIONAL HEALTH SURVEY, FACILITATING THE DEVELOPMENT OF COMPARABLE HEALTH INFORMATION AND STATISTICS AT THE FEDERAL, STATE, AND LOCAL LEVELS, AND FOR OTHER PURPOSES

AND RELATED BILLS

FEBRUARY 17 AND 18, 1970

Part 1

Printed for the use of the Committee on Labor and Public Welfare

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HEART DISEASE, CANCER, STROKE, AND KIDNEY DISEASE AMENDMENTS OF 1970

TUESDAY, FEBRUARY 17, 1970

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Ralph W. Yarborough (chairman of the committee) presiding.

Present: Senators Yarborough (presiding), Hughes, and Javits.

Staff members present: John S. Forsythe, general counsel; James Babin, professional staff member to the subcommittee, and Jay B. Cutler, minority counsel to the subcommittee.

The CHAIRMAN. The Subcommittee on Health will come to order.

I have called these important hearings to consider S. 3355, the Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970, which I introduced on January 29, the bill being cosponsored by a number of other Senators.

This bill amends, extends, and improves title IX of the Public Health Service Act which was set up to provide regional medical programs.

(The text of the bills under consideration follows:)

91ST CONGRESS
2D SESSION

S. 3355

IN THE SENATE OF THE UNITED STATES

JANUARY 29, 1970

Mr. YARBOROUGH (for himself, Mr. JACKSON, Mr. ANDERSON, Mr. BURDICK, Mr. CRANSTON, Mr. EAGLETON, Mr. HART, Mr. HUGHES, Mr. KENNEDY, Mr. MCCARTHY, Mr. MAGNUSON, Mr. METCALF, Mr. MONDALE, Mr. MONTOYA, Mr. NELSON, Mr. PELL, Mr. RANDOLPH, Mr. WILLIAMS of New Jersey, and Mr. YOUNG of Ohio) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend title IX of the Public Health Service Act so as to extend and improve the existing program relating to education, research, training, and demonstrations in the fields of heart disease, cancer, stroke, and other major diseases and conditions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970".

SEC. 2. (a) Section 900(a) of the Public Health Service Act is amended—

(1) by inserting "and contracts" immediately after "grants";

(2) by striking out "related demonstrations" and inserting in lieu thereof "demonstrations";

(3) by striking out "related diseases" and inserting in lieu thereof "kidney disease, and other major diseases and conditions".

(b) Section 900(b) of such Act is amended by striking out "diagnosis and treatment" and inserting in lieu thereof prevention, diagnosis, treatment, and rehabilitation".

(c) Section 900 of such Act is further amended by—

(1) striking out "and" at the end of subsection (b) thereof;

(2) redesignating subsection (c) thereof as subsection (d); and

(3) inserting after subsection (b) thereof a new subsection (c) which reads as follows:

"(c) to promote and foster regional linkages among health care institutions and providers so as to strengthen and improve primary care and the relationship between specialized and primary care; and".

(d) Section 900(d) of such Act (as redesignated by subsection (c)(2) of this section) is amended by striking out "the health manpower and facilities to the Nation" and inserting in lieu thereof "the quality and enhance the ca-

pacity of the health manpower and facilities available to the Nation and to improve health services for persons residing in areas with limited health services".

SEC. 3. (a) (1) The first sentence of section 901 (a) of such Act is amended by striking out "and $120,000,000 for the next fiscal year, for grants" and inserting in lieu thereof "$120,000,000 for the fiscal year ending June 30, 1970, $150,000,000 for the fiscal year ending June 30, 1971, $200,000,000 for the fiscal year ending June 30, 1972, $250,000,000 for the fiscal year ending June 30, 1973, and for each of the next two fiscal years, for grants".

(2) The second sentence of section 901 (a) of such Act is amended to read as follows: "Of the sums appropriated under this section for the fiscal year ending June 30, 1971, not more than $15,000,000 shall be available for activities in the field of kidney disease."

(b) Section 901 (a) of such Act is amended by striking out the period after "title" and inserting "and for contracts to otherwise carry out the purposes of this title".

(c) Section 901 of such Act is further amended by adding at the end thereof the following new subsection:

"(e) At the request of any recipient of a grant under this title, the payments to such recipient may be reduced by the fair market value of any equipment, supplies, or services furnished to such recipient and by the amount of the

pay, allowance, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the regional medical program to which the grant or contract under this title is made."

SEC. 4. Section 902 (a) of such Act is amended by striking out "training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and at the option of the applicant, related disease or diseases" and inserting in lieu thereof "training, prevention, diagnosis, treatment, and rehabilitation relating to heart disease, cancer, stroke, or kidney disease, and, at the option of the applicant, other major diseases or conditions".

SEC. 5. Section 902 (f) is amended by inserting between the words "includes" and "alteration" "new construction of facilities for demonstrations, research, and training when necessary to carry out regional medical programs,"

SEC. 6. Section 903 (b) (4) of such Act is amended—

(1) by striking out "voluntary health agencies, and" and inserting in lieu thereof "voluntary health agencies, official health and planning agencies, and"; and

(2) by striking out "need for the services provided

under the program" and inserting in lieu thereof "need for and financing of the services provided under the program, and which advisory group shall be sufficient in number to insure adequate community orientation".

SEC. 7. That part of the second sentence of section 904 (b) of the Public Health Service Act preceding paragraph (1) is amended by striking out "section 903 (b) (4) and" and inserting in lieu thereof the following: "section 903 (b) (4), if opportunity has been provided, prior to such recommendation, for consideration of the application by each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan area, or other local area plan referred to in section 314 (b) covering any area in which the regional medical program for which the application is made will be located, and if the application".

SEC. 8. Section 905 (a) of such Act is amended—

(1) by striking out "The Surgeon General, with the approval of the Secretary," and inserting in lieu thereof "Secretary";

(2) by striking out "the Surgeon General" and inserting in lieu thereof "the Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs";

(3) by inserting "health care administration," immediately after "the medical sciences,";

(4) by striking out 'study, diagnosis, or treatment of cancer" and inserting in lieu thereof "study or care of cancer"; and

(5) by striking out "and one shall be outstanding in the study, diagnosis, or treatment of stroke" and inserting in lieu thereof "one shall be outstanding in the study or care of stroke, one shall be outstanding in the study or care of kidney disease, and three shall be members of the public".

SEC. 9. Section 907 of such Act is amended by striking out "or stroke," and inserting in lieu thereof "stroke, or kidney disease,".

SEC. 10. Section 909(a) of such Act is amended by inserting "or contract" after "grant", each place it appears therein.

SEC. 11. (a) Section 910 of such Act is amended to read as follows:

"SEC. 910. (a) To facilitate interregional cooperation, and develop improved national capability for delivery of health services, the Secretary is authorized to utilize funds appropriated under this title to make grants to public or nonprofit private agencies or institutions or combinations thereof and to contract for—

"(1) programs, services, and activities of substantial use to two or more regional medical programs;

"(2) development, trial, or demonstration of methods for control of heart disease, cancer, stroke, kidney disease, or other major disease and conditions;

"(3) the collection and study of epidemiologic data related to any of the diseases and conditions referred to in paragraph (2);

"(4) development of training specifically related to the prevention, diagnosis, or treatment of any of the diseases or conditions referred to in paragraph (2), or to the rehabilitation of persons suffering from any of such diseases or conditions; and for continuing programs of such training where shortage of trained personnel would otherwise limit application of knowledge and skills important to the control of any of such diseases or conditions; and

"(5) the conduct of cooperative clinical field trials.

"(b) The Secretary is authorized to assist in meeting the costs of special projects for improving, and developing new means for the delivery of health services concerned with the diseases and conditions with which this title is concerned.

"(c) The Secretary is authorized to support research, studies, investigations, training, and demonstrations designed to maximize the utilization of manpower in the delivery of health services."

(d) The heading to section 910 of such Act is amended to read as follows:

"MULTIPROGRAM SERVICES".

SEC. 12. The heading to title IX of such Act is amended by striking out "STROKE, AND RELATED DISEASES" and inserting in lieu thereof "STROKE, KIDNEY DISEASE, AND OTHER MAJOR DISEASES AND CONDITIONS".

SEC. 13. Sections 902(a), 903(a), 903(b), 904(a), 904(b), 905(b), 905(c), 906, 907, and 909(a) (as amended by the preceding provisions of this Act) are each further amended by striking out "Surgeon General", each place it appears therein, and inserting in lieu thereof "Secretary".

91ST CONGRESS
2D SESSION

S. 3443

IN THE SENATE OF THE UNITED STATES

FEBRUARY 16, 1970

Mr. JAVITS (for himself, Mr. BROOKE, Mr. DOMINICK, Mr. GOODELL, Mr. MURPHY, Mr. PROUTY, Mr. SAXBE, Mr. SCHWEIKER, and Mr. SCOTT) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend and improve the Public Health Service Act to aid in the development of integrated, effective, consumer-oriented health care systems by extending and improving regional medical programs, supporting comprehensive planning of public health services and health services development on a State and areawide level, promoting research and demonstrations relating to health care delivery, encouraging experimentation in the development of cooperative local, State, or regional health care delivery systems, enlarging the scope of the National Health Survey, facilitating the development of comparable health information and statistics at the Federal, State, and local levels, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

That this Act may be cited as the "Health Services Improvement Act of 1970".

AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 2. Title IX of the Public Health Service Act is amended to read as follows:

"TITLE IX—PLANNING, ORGANIZATION AND DELIVERY OF HEALTH SERVICES

"FINDINGS AND PURPOSES

"SEC. 900. (a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful family and individual living; that attainment of this goal depends on an effective partnership among those who provide health and medical care and services, government at all levels, and the consumers of health services; that Federal assistance must be directed to support cooperative efforts aimed at the organization and development of improved systems for the delivery of health care and services of high quality for every person; that the leadership and capacities of those involved in these cooperative efforts must be strengthened; that support of community health services should be continued and strengthened; that these ends should be accomplished through support and encouragement of evolving, innovative patterns, and forms of providing preventive, diagnostic,

therapeutic, and rehabilitative services; that Federal assistance should support cooperative efforts for the organization, development, or establishment of more efficient and effective systems for the delivery of health services, that support of regional and areawide health services programs and comprehensive health planning should be continued; and that support should be given to innovative patterns and methods for delivery of health care services.

"(b) The Congress further declares that in the fulfillment of such general purpose, the purposes of this title are:

"(1) to encourage and assist in the establishment and support of regional medical programs providing regional cooperative arrangements among public or nonprofit private institutions or agencies for improving the quality, distribution, and efficiency of preventive, diagnostic, therapeutic, and rehabilitative services;

"(2) to encourage and assist in the establishment and support of comprehensive health planning agencies at the State and areawide levels which, with involvement of consumers of health services, will examine the relationship between health needs and the distribution and utilization of health resources, and assist in the training of health planners and the development of planning methodologies;

"(3) promote the establishment of more efficient and effective health service systems, assure the coordination of health services programs under this and other titles of this Act with related activities authorized under the Social Security Act and other Federal health programs, as well as with other health related programs and activities, and with particular attention to the relationship between improved organization and delivery of health services and the financing thereof;

"(4) to assist in the support of State programs of public health services, the initial support of new health services, and the support of health services meeting particular needs;

"(5) to provide support for research and development (including demonstrations and training) related to improving the organization, financing, and delivery of health services; and

"(6) to provide support for experiments and demonstrations in the integration and coordination of the programs authorized by this title, and appropriate related programs, leading to the development of improved health systems extending high quality health care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by Federal health programs.

"NATIONAL ADVISORY COUNCIL ON THE PLANNING, ORGANIZATION, AND DELIVERY OF HEALTH SERVICES

"SEC. 901. (a) There is hereby established a National Advisory Council on the Planning, Organization, and Delivery of Health Services, consisting of the Secretary, who shall be Chairman, and twenty-four members, not otherwise in the regular full-time employ of the United States, appointed by the Secretary without regard to the civil service laws. The twenty-four members shall be selected from among persons who are leaders in the fields of the fundamental sciences, the medical sciences, or the organization, delivery, and financing of health care, who are State or local officials, or who are active in consumer affairs, or public or community affairs, or who are representatives of minority groups.

"(b) The Council shall advise and assist the Secretary in the preparation of general regulations to carry out the purposes of this title and on policy matters arising in the administration of this title, including the coordination of programs thereunder with programs authorized under other parts of this Act or under the Social Security Act and other Federal or federally assisted health programs, with particular attention to the relationship between the improved organization and delivery of health services and the financing of such services; and shall, in carrying out such functions, review,

not less often than annually, the grants made under this title to determine their effectiveness in carrying out its purposes.

"(c) The Secretary shall make appropriate provision for consultation between and coordination of the work of the Council, the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, the Medical Assistance Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this title and the coordination of programs under this title with related Federal health programs.

"(d) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, six at the end of the first year, six at the end of the second year, six at the end of the third year, and six at the end of the fourth year after the date of appointment. No member may be reappointed unless at least one year has elapsed since the end of his last full term.

"(e) Members of the Council, who are not in the regular full-time employ of the United States, while attending

meetings of the Council or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 5703 (b)) for persons in the Government service employed intermittently.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 902. (a) There are authorized to be appropriated for the fiscal year ending June 30, 1971 and for each of the next two fiscal years, such sums as may be necessary for grants and contracts under part A of this title. Sums so appropriated for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made.

"(b) There are authorized to be appropriated for the fiscal year ending June 30, 1971, and for each of the next two fiscal years, such sums as may be necessary, for grants and contracts under part B of this title.

"(c) There are authorized to be appropriated for the fiscal year ending June 30, 1971, and for each of the next two fiscal years, such sums as may be necessary to carry

out the other provisions of this title, including grants to public or nonprofit private agencies and organizations, and contracts with public or private agencies, and technical assistance with respect to cooperative planning and experimentation related to organizing and developing health care systems, including planning for the manpower, services, and facilities necessary therefor, and promotion of effective combination or coordination of public and private methods and systems for the delivery of health services at regional, State, and local levels, including the integration of regional medical programs and comprehensive health planning activities authorized under this title.

"PART A—REGIONAL MEDICAL PROGRAMS

"DEFINITIONS

"SEC. 911. For the purposes of this part—

"(1) The term 'regional medical program' means a cooperative arrangement among a group of public or nonprofit institutions or agencies (i) engaged in planning, research, training, prevention, diagnosis treatment, and rehabilitation relating to such one or more diseases and impairments of man as may be required by regulations and, at the option of the applicant, such other diseases and impairments of man as may be permitted in such regulations, and (ii) engaged in, in appropriate cases (as determined under regulations), developing and demonstrating

systems for organizing and delivering medical care; but only if such group—

"(A) is situated within a geographic area, composed of any part or parts of any one or more States, which the Secretary determines, in accordance with regulations, to be appropriate in carrying out the purpose of this part;

"(B) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

"(C) has in effect cooperative arrangements among its component units which the Secretary finds will be adequate for effectively carrying out the purposes of this part.

"(2) The term 'medical center' means a medical school or other medical institution involved in postgraduate medical training and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

"(3) The term 'clinical research center' means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

"(4) The term 'hospital' means a hospital as defined in section 625(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this part.

"(5) The term 'construction' means alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"GRANTS FOR PLANNING

"SEC. 912. (a) The Secretary, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist them in planning the development of regional medical programs.

"(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such application for a planning grant may be approved only if it meets the requirements of section 914 and contains or is supported by a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and the institutions and the agencies participating in the resulting regional medical program) in formulating and carrying out

the plan for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, State or local public or nonprofit private health agencies, health planning agencies established pursuant to section 922, representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program, including the financing or evaluation of such activities, and representatives of consumers of health services (including the poor and minority groups) familiar with the community's needs with respect to the services provided under the program.

"GRANTS FOR ESTABLISHMENT AND OPERATION

"SEC. 913. (a) The Secretary, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist in the establishment and operation of regional medical programs, including construction and equipment of facilities in connection therewith and including training and continuing education.

"(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such

application may be approved only if it is recommended by the advisory group described in section 912(b), meets the requirements of section 914, and contains or is supported by reasonable assurance that—

"(1) satisfactory efforts will be undertaken by the applicant to obtain financing from non-Federal sources, and from Federal sources providing reimbursement for medical care for eligible beneficiaries, to support the program after such period of initial support under this section as may be prescribed by regulations; and

"(2) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a–5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"GENERAL CONDITIONS OF GRANTS

"SEC. 914. Grants may not be made under this part unless the applicant also gives reasonable assurance that—

"(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) in the case of an application under section 913, will not supplant funds that are otherwise available for establishment or operation of the regional medical program with respect to which the grant is made;

"(2) the applicant will provide for such fiscal control and fund accounting procedures as are required by the Secretary to assure proper disbursement of and accounting for such Federal funds;

"(3) the applicant will make such reports, in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

"(4) reasonable opportunity has been provided, prior to submission of the application, for review and comment by the appropriate State health planning agency or agencies designated pursuant to section 921 of this title, and by the agency or agencies conducting the comprehensive regional, metropolitan, or other area planning referred to in section 922 of this title or, if

there is no such agency in the area where the project is to be located, such other public or nonprofit private agency or organization performing similar planning functions as may be determined in accordance with criteria prescribed by the Secretary.

"INFORMATION ON SPECIAL TREATMENT AND TRAINING RESOURCES

"SEC. 915. The Secretary shall provide, either directly or through grants or contracts, for the establishment, and maintenance on a current basis, of (1) a list or lists of facilities in the United States equipped and staffed to provide advanced methods and techniques in the prevention, diagnosis, and treatment, of such diseases and impairments of man as may be prescribed by the Secretary for the purposes of this section, and in the rehabilitation of persons suffering from such diseases and impairments, and (2) such related information as trends in equipment, staffing, and services and the distribution of various types of such facilities in the United States, and (3) the availability of advanced specialty training in such facilities.

"PROJECT GRANTS FOR MULTIPROGRAM SERVICES AND CONTRACTS FOR CLINICAL AND FIELD STUDIES

"SEC. 916. Funds appropriated to carry out this part shall also be available for (a) grants to any public or nonprofit private agency or institution for services needed by, or

which will be of substantial use to any two or more regional medical programs, and (b) contracts with public or private agencies and institutions for the conduct of cooperative clinical and field studies and demonstrations of systems for organizing and delivering medical care and of other activities for which support is authorized pursuant to this part.

"PART B—COMPREHENSIVE STATE AND AREAWIDE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

"GRANTS FOR COMPREHENSIVE STATE HEALTH PLANNING

"State Plans

"SEC. 921. (a) In order to be approved for purposes of assistance under this section, a State plan for comprehensive State health planning must—

"(1) designate, or provide for the establishment of, a State agency, which may be an interdepartmental agency, as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;

"(2) provide for a State health planning advisory council which shall include representatives of State and local agencies, and public and private agencies and organizations concerned with health and with the financing of health services (including representation of the regional medical program or programs within the State established pursuant to part A of this title), and of

consumers of health services, and with one member being a representative of the regional medical programs and with a majority of the membership of such council consisting of representatives of consumers of health services (including an appropriate number of representatives of poor and minority groups as determined in accordance with regulations promulgated by the Secretary);

"(3) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Secretary are designed to provide for comprehensive State planning for health services (both public and private), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State;

"(4) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation;

"(5) contain or be supported by assurances satisfactory to the Secretary that the funds paid under this subsection will be used to supplement and, to the extent

practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

"(6) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

"(7) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

"(8) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Secretary appropriate modifications thereof;

"(9) (A) provide for assisting each health care facility in the State to develop a program for capital

expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria established by the Secretary after consultation with the States which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner;

"(B) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (A)) of each health care facility in the State and recommended appropriate modification thereof; and

"(C) provide that in carrying out its functions under this subsection, such State agency shall, in each case, consult with the agency or organization which has developed the applicable comprehensive regional, metropolitan, or other area plan referred to in section 922 of this part, or, where there is no such agency, such other public or nonprofit private agency performing similar planning functions (as determined in accordance with criteria prescribed by the Secretary);

"(10) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this section: and

"(11) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this section.

"State Allotments

"(b) (1) From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year to carry out the purposes of this section.

"(2) The amount of any allotment to a State under paragraph (1) for any fiscal year which the Secretary determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallotment by the Secretary from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under paragraph (1) for such fiscal year, but with such proportionate amount for any such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly

reallotted among the States whose proportionate amounts were not so reduced. Any amount so reallotted to a State from funds appropriated pursuant to this section for a fiscal year shall be deemed part of its allotment under paragraph (1) such fiscal year.

"Payments to States

"(c) From each State's allotment for a fiscal year under this section, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this section. Such payments shall be made on the basis of estimates by the Secretary of the sums the State will need in order to perform the planning under its approved State plan under this section, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The 'Federal share' for any State for purposes of this section shall be such percentage as the Secretary may determine, except that it shall in no event exceed 75 per centum.

"PROJECT GRANTS FOR AREAWIDE HEALTH PLANNING

"SEC. 922. (a) The Secretary is authorized—

"(1) to make, with the approval of the State comprehensive health planning agency administering or supervising the administration of the State plan ap-

proved under section 921(a), project grants to any other public or nonprofit private agency or organization to cover the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for the provision, financing, and coordination of existing and planned health services, including the facilities and persons required for the provision of such services;

"(2) to make project grants to such a State comprehensive health planning agency for provision of assistance in the development (and revision from time to time) of comprehensive plans described in clause (1) with respect to any area or areas of the State with respect to which grants have not been made under paragraph (1). No such grant for any project may exceed 75 per centum of the cost thereof.

"(b) In order to be approved for purposes of this section, an application must include or be accompanied by assurances that there has been or will be established, an areawide health planning council, to advise the recipient of the grant in carrying out the project referred to in subsection (a), which shall include representatives of public and private agencies and organizations concerned with health and with the financing of health services (including representation

of the interests of local government where the recipient of the grant is not a local government or combination thereof or any agency of such government or combination, and of any regional medical program carrying out activities within the area and established pursuant to part A of this title), and of consumers of health services, and with one member being a representative of the regional medical programs and with a majority of the membership of such council consisting of representatives of consumers of health services (including an appropriate number of representatives of poor and minority groups as determined in accordance with regulations).

"PROJECT GRANTS AND CONTRACTS FOR TRAINING, STUDIES, AND DEMONSTRATIONS

"SEC. 923. The Secretary is also authorized to make grants to any public or nonprofit private agency, institution, or other organization, or to enter into contracts with public or private agencies, institutions, organizations, or individuals, to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation.

"GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

"Availability of Appropriations

"SEC. 924. (a) Sums appropriated to carry out the purposes of this section shall be available for making pay-

ments to States which have submitted, and had approved by the Secretary, State plans for provision of public health services.

"State Plans for Provision of Public Health Services

"(b) In order to be approved under this section, a State plan for provision of public health services must—

"(1) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

"(2) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

"(3) indicate the relationship of the activities included in the plan to the total health program of the State, including health activities which are the responsibility of State agencies other than the State health and mental health authorities and including programs concerned with the financing of medical care;

"(4) contain or be supported by assurances satisfactory to the Secretary that (A) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people;

(B) such funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Secretary determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; and (C) such funds will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds;

"(5) provide for the furnishing of public health services in accordance with such plans as have been developed pursuant to section 921 of this part;

"(6) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

"(7) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such

methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

"(8) provide that the State health authority or, with respect to mental health services, the State mental health authority, will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection and submit to the Secretary appropriate modifications thereof;

"(9) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

"(10) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this section;

"(11) be approved by the State agency administering or supervising the administration of the State plan approved under section 921 if the Governor certifies such agency is ready to perform such function; and

"(12) contain such additional information and as-

surances as the Secretary may find necessary to carry out the purposes of this section.

"State Allotments and Payments

"(c) (1) From the sums appropriated to carry out the provisions of this section the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States, except that no State's allotment shall be less for any year than the total amounts allotted to such State under formula grants for cancer control, plus other allotments under section 314, for the fiscal year ending June 30, 1967.

"(2) (A) From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this section. Such payments shall be made from time to time in advance on the basis of estimates by the Secretary of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this section.

"(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be

regarded as expenditures by such State or a political subdivision thereof.

"Federal Share

"(d) The 'Federal share' for any State for purposes of this section shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than $33\frac{1}{3}$ per centum or more than $66\frac{2}{3}$ per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Virgin Islands shall be $66\frac{2}{3}$ per centum.

"Determination of Federal Shares

"(e) The Federal shares shall be determined by the Secretary between July 1 and September 30 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

"Allocation of Funds Within the States

"(f) At least 15 per centum of a State's allotment under this section shall be available only to the State mental health authority for the provision under the State plan of mental health services. At least 70 per centum of such amount reserved for mental health services and at least 70 per centum of the remainder of a State's allotment under this section shall be available only for the provision under the State plan of services in communities of the State.

"PROJECT GRANTS FOR HEALTH SERVICES DEVELOPMENT

"SEC. 925. The Secretary is authorized to make grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including amortization of loans on facilities) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Such grants may be made only if the application therefor contains (A) satisfactory evidence that reasonable opportunity has been provided, prior to submission of the application, for review and comment with respect to the application by the agency conducting the comprehensive regional, metropolitan, or other area planning referred to in section 922 or, if there is no such agency in the area

where the project is to be located, such other public or nonprofit private agency or organization performing similar planning functions as determined in accordance with criteria prescribed by the Secretary; and (B) reasonable assurance that efforts will be undertaken by the applicant for a project grant described in clause (2) of the preceding sentence to obtain financing from non-Federal sources, and from Federal sources providing reimbursement for medical care for eligible beneficiaries, to support the project after such period of initial support under this section as may be prescribed by regulations.

"WITHHOLDING OF PAYMENTS

"SEC. 926. Whenever the Secretary after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to paragraph (1) of subsection (a) of section 921, finds that, with respect to money paid to the State out of appropriations under section 921 or 924, there is a failure to comply substantially with either—

"(1) the applicable provisions of this part;

"(2) the State plan submitted under such section; or

"(3) applicable regulations under this part;

the Secretary shall notify such State health authority, mental

health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such section (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Secretary shall make no payment to such State from appropriations under such section, or shall limit payment to activities in which there is no such failure.

"PART C—HEALTH FACILITIES AND SERVICES RESEARCH AND DEMONSTRATION

"GRANTS AND CONTRACTS FOR RESEARCH, EXPERIMENTS, DEMONSTRATION AND TRAINING

"SEC. 931. The Secretary is authorized—

"(1) to make grants to States, political subdivisions, universities, hospitals, and other public or nonprofit private agencies, institutions, or organizations for projects for the conduct of research, experiments, or demonstrations (and related training), and,

"(2) to make contracts with public or private agencies, institutions, or organizations for the conduct of research, experiments, or demonstrations (and related training),

relating to the development, utilization, quality, organiza-

tion, and financing of services, facilities, and resources of hospitals, facilities for long-term care, or other medical facilities (including, for purposes of this section, facilities for the mentally retarded, as defined in the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963), agencies, institutions, or organizations or to the development of new methods or improvement of existing methods of organization, delivery, or financing of health services, including, among others—

"(A) projects for the construction of units of hospitals, facilities for long-term care, or other medical facilities which involve experimental architectural designs or functional layout or use of new materials or new methods of construction, the efficiency of which can be tested and evaluated, or which involve the demonstration of such efficiency, particularly projects which also involve research, experiments, or demonstrations relating to delivery of health services, and

"(B) projects for development and testing of new equipment and systems, including automated equipment, and other new technology systems or concepts for the delivery of health services, and

"(C) projects for research and demonstration in new careers in health manpower and new ways of educating and utilizing health manpower.

"FEDERAL PARTICIPATION

"SEC. 932. Except where the Secretary determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of this part, a grant or contract under section 931 with respect to any project for construction of a facility or for acquisition of equipment may not provide for payment of more than 50 per centum of so much of the cost of a facility or equipment as the Secretary determines is reasonably attributable to research, experimental, or demonstration purposes. The provisions of clause (5) of the third sentence of section 605 (a) and such other conditions as the Secretary may determine shall apply with respect to grants or contracts under this section for projects for construction of a facility or for acquisition of equipment.

"PAYMENTS

"SEC. 933. Payments of any grants or under any contracts under this part may be made in advance or by way of reimbursement, and in such installments and on such conditions, as the Secretary deems necessary to carry out the purposes of this part.

"PART D—GENERAL

"DEFINITIONS

"SEC. 941. For purposes of this title—

"(1) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory

of the Pacific Islands, the Virgin Islands, and the District of Columbia and the term 'United States' means the fifty States and the District of Columbia.

"(2) The term 'Council' means the National Advisory Council on the Planning, Organization, and Delivery of Health Services established pursuant to section 901, unless the context otherwise requires.

"(3) The term 'nonprofit' as applied to any private agency, institution, or organization means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"GRANTS OF EQUIPMENT, SUPPLIES AND SERVICES

"SEC. 942. The Secretary, at the request of any recipient of a grant or contract under this title, may reduce the payments of such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant

or contract under this title is made. The amount by which such payments are so reduced shall be available for payment of such cost (including the costs of such equipment and supplies) by the Secretary, but shall, for purposes of determining the Federal share under section 921 or 924 be deemed to have been paid to the State.

"JOINT FUNDING

"SEC. 943. (a) Pursuant to regulations prescribed by the Secretary, where funds are advanced for a single project pursuant to the authority of more than one statute administered by the Department of Health, Education, and Welfare, any one administrative unit within the Department may be designated to act for all in administering the funds advanced. In such cases, a single non-Federal share or participation requirement may be established according to the proportion of funds advanced under each authorization and any such administrative unit may waive any technical grant or contract requirement (as defined by such regulations) which is inconsistent with the similar requirements of the administering unit or which such unit does not impose.

"(b) Pursuant to regulations prescribed by the President, where funds are advanced for a single project by more than one Federal agency to an agency or organization assisted under this title, any one Federal agency may be designated to act for all in administering the funds advanced.

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In such cases, a single non-Federal share requirement may be established according to the proportion of funds advanced by each Federal agency, and any such agency may waive any technical grant or contract requirement (as defined by such regulations) which is inconsistent with the similar requirements of the administering agency or which the administering agency does not impose.

"TRANSFER OF FUNDS

"SEC. 944. Notwithstanding any limitation on appropriations for any program or activity under this title, not to exceed 10 per centum of the amount appropriated to carry out any such program or activity, other than amounts appropriated to carry out section 921 or 924, may be transferred and used by the Secretary for the purpose of carrying out any other such program or activity under this title other than activities under such section 921 or 924, but no such transfer may result in increasing the amounts otherwise available for carrying out programs or activities under any section of this title by more than 10 per centum.

"ANNUAL REPORT

"SEC. 945. On or before January 1 of each year, the Secretary, after consultation with the Council, shall transmit to the Congress a report of the activities under this title together with (1) an evaluation of the effectiveness of these activities in improving the efficiency and effectiveness of

the delivery of health services and in carrying out the other purposes of this title, (2) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, including efforts by the grantees to develop alternate sources of financing after an initial period of support, and (3) such recommendations with respect to modifications of this title as he deems appropriate.

"REGULATIONS

"SEC. 946. The Secretary may, after consultation with the Council, prescribe regulations relating to the general administration of this title and the terms and conditions for approving applications for assistance thereunder, and relating to methods for the coordination of programs assisted under this title with other Federal or federally assisted health programs.

"RECORDS AND AUDIT

"SEC. 947. (a) Each recipient of a grant under this title (other than sections 921 or 924) shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

"(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any such grant which are pertinent thereto.

"(c) In carrying out their functions under this section, the Secretary and the Comptroller General shall take such steps as are reasonably necessary to protect the integrity of the doctor-patient relationship and the confidentiality of information disclosed during the course thereof."

COOPERATIVE SYSTEM OF HEALTH INFORMATION AND STATISTICS

SEC. 3. (a) (1) Clause (1) of subsection (a) of section 305 of the Public Health Service Act is amended by striking out "and" before "(E)", and by inserting after the semicolon at the end of such clause: "(F) health care resources; (G) environmental and social health hazards; and (H) family formation, growth, and dissolution;".

(2) Such subsection is further amended by adding at the end thereof the following new sentence: "No disclosure of any information obtained in accordance with this paragraph may be used for any purpose other than the statistical purposes for which it was supplied except pursuant to regulations of the Secretary; nor may any such information be published if the particular establishment or person supplying

it is identifiable except with the consent of such establishment or person."

(b) Section 305 is further amended by redesignating subsections (b), (c), and (d) as subsections (c), (d), and (e), respectively, and by adding after subsection (a) the following new subsection:

"(b) The Secretary is authorized, directly or by contract, to undertake research, development, demonstration, and evaluation, relating to the design and implementation of a cooperative system for producing comparable and uniform health information and statistics at the Federal, State, and local levels."

SEC. 4. (a) Section 314 of the Public Health Service Act is amended by striking out subsections (a), (b), (c), (d), (e), and (g).

(b) Such Act is further amended by—

(1) striking out "(f)" at the beginning of that subsection of section 314 and inserting in lieu thereof "SEC. 314.";

(2) by redesignating paragraphs (1) through (9) of that subsection, and references thereto, as subsections (a) through (i), respectively, of section 314;

(3) by redesignating subparagraphs (A) through (D) in the paragraph herein redesignated as subsec-

tion (c), and references thereto, as paragraphs (1) through (4), respectively;

(4) by redesignating clauses (i) through (iv) in the subparagraph herein redesignated as paragraph (3) of subsection (c), and references thereto, and as subparagraphs (A) through (D), respectively;

(5) by redesignating subparagraphs (A) and (B) of the paragraph herein redesignated as subsection (g), and references thereto, as paragraphs (1) and (2), respectively;

(6) by redesignating clauses (I) and (II) of the subparagraph herein redesignated as subparagraph (D) of subsection (c) of section 314, and references thereto, as clauses (i) and (ii), respectively, of such subparagraph (D).

(c) Section 304 of such Act is repealed.

EFFECTIVE DATE

SEC. 5. The amendments and repeals effected by sections 2 and 4 shall apply with respect to allotments or grants made from appropriations for any fiscal year beginning after June 30, 1970 and contracts entered into after such date.

91ST CONGRESS
1ST SESSION

S. 88

IN THE SENATE OF THE UNITED STATES

JANUARY 15 (legislative day, JANUARY 10), 1969

Mr. JACKSON (for himself and Mr. MAGNUSON) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide for a comprehensive review of the medical, technical, social, and legal problems and opportunities which the Nation faces as a result of medical progress toward making transplantation of organs, and the use of artificial organs a practical alternative in the treatment of disease; to amend the Public Health Service Act to provide assistance to certain non-Federal institutions, agencies, and organizations for the establishment and operation of regional and community programs for patients with kidney disease and for the conduct of training related to such programs; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Artificial Organ, Transplantation, and Technological Development Act of 1969".

SEC. 2. Part B of title III of the Public Health Service Act is amended by adding at the end thereof the following new sections:

"THE NATIONAL COMMISSION ON TRANSPLANTATION AND ARTIFICIAL ORGANS

"SEC. 319. (a) There is established the National Commission on Transplantation and Artificial Organs (hereinafter in this section referred to as the 'Commission').

"(b) The Commission shall be composed of seven members, who shall be appointed by the President, by and with the advice and consent of the Senate. Members shall serve at the pleasure of the President. No member of the Commission shall, during his period of service on the Commission, hold any other position as an officer or employee of the United States, except as a retired officer or retired civilian employee of the United States.

"(c) The President shall designate a Chairman of the Commission (hereinafter in this section referred to as the 'Chairman') from among its members.

"(d) Members of the Commission may each be compensated at the rate of $100 for each day such member is engaged in the actual performance of duties vested in the Commission. Each member shall be reimbursed for travel expenses, including per diem in lieu of subsistence, as author-

ized by law (5 U.S.C. 5703) for persons in the Government service employed intermittently.

"(e) The Commission shall have an Executive Director, who shall be appointed by the Chairman with the approval of the President and shall be compensated at the rate provided by law for level IV of the Federal Executive Salary Schedule. The Executive Director shall have such duties and responsibilities as the Chairman may assign.

"(f) In making appointments to the Commission, the President shall assure that appointees are qualified by professional training and accomplishment to appreciate the full range of medical, legal, social, economic, technical, humanitarian, and other problems which are relevant to present and future decisions involving the role of the Federal Government in the prevention and treatment of diseases in which the use of transplantation or artificial organs may be a factor.

"(g) The Commission shall (1) review present and anticipated medical, technical, social, and legal problems associated with the development of the knowledge and technology necessary to make transplantation and the use of artificial organs a practical and readily available alternative in the treatment of disease; (2) make projections of the public's need for readily available facilities and technology for organ transplantation and utilization of artificial organs;

(3) consider the economic, legal, and social ramifications of alternative ways in which the Federal Government could participate in developing the necessary knowledge and facilities to make transplantation and the use of artificial organs a practical and readily available alternative in the treatment of disease; (4) review and report on the activities of Federal, State, and local government and private institutions in this area of medicine; and (5) advise on such specific related problems as may be referred to it by the President and the Secretary.

"(h) The Commission shall consult with the Secretary regarding its studies and shall furnish its proposed reports and recommendations to the Secretary for review and comment. The Commission shall submit to the President such interim and final reports as it deems appropriate, and the Secretary shall submit to the President his views on the Commission's report. The President shall transmit the Commission's final report to the Congress together with such comments and recommendations for legislation as he deems appropriate.

"(i) The Commission shall terminate not later than three years from the effective date of the Artificial Organ, Transplantation, and the Technological Development Act of 1968.

"(j) The Commission may (1) hold such hearings, sit and act at such times and places, take such testimony, and

receive such evidence as it may deem advisable; (2) acquire, furnish, and equip such office space as is necessary; (3) use the United States mails in the same manner and upon the same conditions as other departments and agencies of the United States; (4) without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, employ and fix the compensation of such personnel as may be necessary to carry out the functions of the Commission; (5) procure services as authorized by section 3109 of title 5, United States Code, at rates not to exceed $100 per diem for individuals; (6) enter into contracts or agreements for studies and surveys with public and private organizations and transfer funds to Federal agencies to carry out such aspects of the Commission's functions as the Commission determines can best be carried out in that manner; and (7) incur such necessary expenses and exercise such other powers as are consistent with and reasonably required to perform its functions under this section.

"(k) Subject to general policies adopted by the Commission, the Chairman shall be the chief executive of the Commission and shall exercise its executive and administrative powers as set forth in subsection (j) of this section.

"(l) The Chairman may make such provision as he shall deem appropriate authorizing the performance of any of his executive and administrative functions by the Executive Director or other personnel of the Commission.

"(m) The Commission may, to the extent practicable, utilize the services of existing Federal health agencies.

"(n) Upon request of the Commission, the head of any Federal department or agency is authorized (1) to furnish to the Commission, to the extent permitted by law and within the limits of available funds, including funds transferred for that purpose pursuant to subsection (j) (6) of this section, such information as may be necessary for carrying out its functions and as may be available to or procurable by such department or agency, and (2) to detail to temporary duty with this Commission on a reimbursable basis such personnel within his administrative jurisdiction as it may need or believe to be useful for carrying out its functions, each such detail to be without loss of seniority, pay, or other employee status.

"(o) Financial and administrative services (including those related to budgeting, accounting, financial reporting, personnel, and procurement) shall be provided the Commission by the General Services Administration, for which payment shall be made in advance, or by reimbursement from funds of the Commission in such amounts as may be agreed

upon by the Chairman of the Commission and the Administrator of General Services: *Provided,* That the regulations of the General Services Administration for the collection of indebtedness of personnel resulting from erroneous payments (5 U.S.C. 5514 (b)) shall apply to the collection of erroneous payments made to or on behalf of a Commission employee, and regulations of said Administrator for the administrative control of funds (31 U.S.C. 665 (g)) shall apply to appropriations of the Commission: *And provided further,* That the Commission shall not be required to prescribe such regulations.

"ESTABLISHMENT AND OPERATION OF REGIONAL AND COMMUNITY PROGRAMS FOR THE PREVENTION AND TREATMENT OF KIDNEY DISEASE

"SEC. 320. (a) It is the purpose of this section to provide financial support through grants to public and other nonprofit schools of medicine, hospitals, agencies, and institutions to assist in the establishment and operation of regional and community prevention and treatment programs for patients with kidney diseases and for training related to such programs.

"(b) There are hereby authorized to be appropriated the sums of $20,000,000 in the fiscal year ending June 30, 1969; and $30,000,000 for each succeeding fiscal year until and including the fiscal year ending June 30, 1973, to enable

the Secretary to carry out the purposes of this section and section 321 of this Act.

"(c) The Secretary shall, after consultation with the National Advisory Committee on Kidney Disease Programs (established pursuant to section 321 of this title), prescribe general regulations and guidelines concerning (1) eligibility of public or nonprofit agencies, institutions, or organizations for grants under this section, (2) determination of costs with respect to which such grants may be made, (3) the terms and conditions under which such grants will be made, and (4) the assurance that all grants are coordinated with any existing regional plan for a kidney disease program in a particular area.

"(d) There is hereby established in the Department of Health, Education, and Welfare the Office for Kidney Centers, for the purpose of administering sections 320 and 321 of this Act and providing coordination of Federal activities in the prevention and treatment of kidney disease. The Secretary is authorized to appoint a Director and such additional personnel as are required to perform the responsibilities specified in this Act and such additional responsibilities as the Secretary may assign to the Office for Kidney Centers.

"(e) Subject to the regulations and guidelines established pursuant to subsection (c) the Office for Kidney Centers shall assist in establishing kidney center programs. This

assistance shall consist of providing information, services, and grants for planning, training, construction, renovation, and percentage contributions towards the operation of kidney centers.

"(f) A 'kidney center' for the purpose of this section means:

"(1) A 'regional kidney center' established within or as a part of a medical school or hospital that has demonstrated a high level of professional competence in relevant medical disciplines. The purpose of the regional kidney center would be:

"(i) to train medical and supporting personnel;

"(ii) to provide transplantation treatment for patients with chronic uremia where this form of therapy is indicated;

"(iii) to provide dialysis treatment when medically indicated in connection with training, research, and transplantation;

"(iv) to engage in research and the development of new techniques;

"(v) to coordinate with and establish appropriate relations with one or more local community dialysis units (described in subsection (f) (2));

"(vi) and, to assure that knowledge and treat-

ment of kidney disease will evolve in a balanced fashion;

"(2) A local 'community dialysis unit' established in conjunction with and in continuing relationship with a 'regional kidney center.' The purpose of a community dialysis unit would be:

"(i) to provide a central training and treatment facility for the care of persons having chronic kidney disease;

"(ii) to provide training and supervision to physicians, staff members, and to patients who are candidates for home dialysis;

"(iii) to foster and promote the availability and wider use of the equipment and techniques of home dialysis.

"(g) The amount of any grant to carry out the purposes of this section shall include:

"(1) 100 per centum of the costs directly related to the training of physicians, staff members, patients, and their families;

"(2) 100 per centum of the costs for construction or renovation of existing facilities and for the necessary equipment to establish a Regional Kidney Center under the provisions of subsection (f) (1);

"(3) 60 to 90 per centum of the costs for construc-

tion or renovation of existing facilities and for the necessary equipment to establish a community dialysis unit under the provisions of subsection (f) (2). The percentage contribution shall be determined on the basis of the economic status of the particular community involved pursuant to guidelines established by the Secretary.

"(4) 90 per centum in the first year of full operation, 60 per centum in the second year, and 30 per centum in the third year and thereafter of the operation and maintenance costs of regional kidney centers and community dialysis units established pursuant to this Act: *Provided, however,* That grants under this subsection may be in lesser amount if the Secretary determines that centers and units are capable of meeting a larger share of costs of operation.

"(h) Three years after the Secretary formally publishes notice in the Federal Register that applications will be received for grants under this section, the President will transmit to the Congress any recommendations he may wish to make concerning the program. In the event that no changes are made in the authorizing legislation, the program shall continue as authorized under this section and section 321.

"SEC. 321. (a) There is hereby established a National Advisory Committee on Kidney Disease Programs. The

Committee shall consist of four members currently in Government service and eight members, not otherwise in the employ of the United States, appointed by the Secretary and without regard to the civil service laws, who are leaders in the fields of the basic medical sciences related to kidney disease, kidney disease diagnosis and treatment, community health programs, or public affairs.

"(b) Each appointed member of the Committee shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term and except that the term of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the end of the third year after the date of appointment. An appointed member shall not be eligible to serve for more than two terms.

"(c) Appointed members of the Committee while attending meetings or conferences thereof or otherwise serving on the business of the Committee shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title

5, United States Code, for persons in the Government service employed intermittently.

"(d) The Committee shall advise and assist the Secretary in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this section insofar as it pertains to kidney disease, or the diagnosis, treatment, and care of patients suffering from such diseases. After the Committee is established, it shall consider all applications for grants under section 320 which pertain to kidney diseases, or the diagnosis, treatment, and care of patients suffering from such diseases and shall make recommendations to the Secretary with respect to approval of application for and the amounts of such grants.

"(e) The Committee shall also review and make recommendations on kidney disease programs of departments and agencies of the Federal Government, including, but not limited to, those in the Veterans' Administration, the Public Health Service, and the Vocational Rehabilitation Administration, so that the methods, facilities, and programs of these administrative agencies can best be utilized in supporting programs for prevention and treatment of kidney disease. Particular attention shall be paid to the coordination of activities of these various agencies in a given region so as to insure adequate geographical distribution of services and avoid duplication of facilities and services."

SEC. 3. (a) Section 226(d) of the Social Security Act is amended to read as follows:

"(d) (1) Any individual who requires continuous intermittent dialysis in the treatment of kidney failure for maintenance of life and rehabilitation shall, subject to section 1862 (c), be entitled to hospital insurance benefits under part A of title XVIII for each month for which he requires such treatment (or any other treatment described in section 1861 (s) (4) (B)), beginning with the first such month.

"(2) For entitlement to hospital insurance benefits in the case of certain other uninsured individuals, see section 103 of the Social Security Amendments of 1965."

(b) Section 1836(1) of the Social Security Act is amended to read as follows:

"(1) (A) has attained the age of 65, or (B) requires continuious intermittent dialysis in the treatment of kidney failure for maintenance of life and rehabilitation, and".

(c) Section 1837 of such Act is amended by adding at the end thereof the following subsection:

"(f) Notwithstanding the preceding provisions of this section, an individual who satisfies section 1836(1) by reason of clause (B) thereof may enroll at any time."

(d) (1) Section 1838(a)(2) of such Act is amended by striking out the period at the end of subparagraph (E)

and inserting in lieu thereof ", or", and by adding after subparagraph (E) the following new subparagraph:

"(F) in the case of an individual who enrolls pursuant to subsection (f) of section 1837, the first day of the month in which he so enrolls."

(2) Section 1838(b) of such Act is amended by striking out the period at the end of paragraph (2) and inserting in lieu thereof ", or", and by inserting immediately after paragraph (2) the following new paragraph:

"(3) in the case of an individual who does not satisfy section 1836(1) by reason of clause (A) thereof, upon his ceasing to satisfy such section by reason of clause (B) thereof."

(3) Section 1838(b) of such Act is further amended by adding at the end thereof the following new sentence: "The termination of a coverage period under paragraph (3) shall take effect at the close of the calendar quarter in which the individual ceases to satisfy section 1836(1) by reason of clause (B) thereof."

(e) Section 1861(s)(4) of the Social Security Act is amended by inserting "(A)" after "(4)", and by adding at the end thereof the following new subparagraph:

"(B) continuous intermittent dialysis and any other items or services required for or in connection with the

treatment of kidney failure (including items or services under the supervision of a physician, furnished in a place of residence used as the patient's home, if the provision of such items or services meets such conditions relating to health and safety as the Secretary may find necessary) ;".

(f) Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(c) Notwithstanding any other provision of this title, in the case of an individual who is entitled to hospital insurance benefits solely by reason of section 226(d) (1) or who satisfies section 1836(1) solely by reason of clause (B) thereof, no payment may be made under part A or part B for any expenses except those incurred for items or services (including continuous intermittent dialysis and kidney transplantation) which are necessitated by such individual's kidney failure or by conditions directly or indirectly related thereto or caused thereby."

SEC. 4. The Secretary of Health, Education, and Welfare is authorized and directed to study the effectiveness of the coverage extended by the amendments made by section 3 of this Act to individuals with kidney failure, giving particular attention to the need for increasing the duration of the benefits provided in the case of such individuals and for any

other adjustments which may be indicated because of the unique nature of their condition and the treatment required. Within six months after the effective date of this Act the Secretary shall transmit to the President and the Congress a report containing his findings of fact and any conclusions or recommendations he may have.

SEC. 5. The head of each department, agency and instrumentality of the United States is authorized and directed to cooperate with the Secretary of Health, Education, and Welfare, to the maximum extent possible, in carrying out the provisions of this Act.

SEC. 6. Except as otherwise specifically provided by any amendment made by this Act, there is authorized to be appropriated such sums as may be necessary to carry out the provisions of this Act.

SEC. 7. The foregoing provisions of this Act shall become effective as of the first day of the first month which begins after the date of enactment of this Act.

91ST CONGRESS
1ST SESSION

S. 2457

IN THE SENATE OF THE UNITED STATES

JUNE 19, 1969

Mr. HARTKE introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide assistance to certain non-Federal institutions, agencies, and organizations for the establishment and operation of cooperative and community programs for patients with kidney disease and for the conduct of training related to such programs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Kidney Disease Treatment and Prevention Act of 1969."

SEC. 2. Part B of title III of the Public Health Service Act is amended by adding at the end thereof the following new sections:

"ESTABLISHMENT AND OPERATION OF COOPERATIVE AND COMMUNITY PROGRAMS FOR THE PREVENTION AND TREATMENT OF KIDNEY DISEASE

"SEC. 319. (a) It is the purpose of this section to provide financial support through grants to public and other nonprofit schools of medicine, hospitals, agencies, and institutions to assist in the establishment and operation of cooperative and community prevention and treatment programs for patients with kidney diseases and for training related to such programs.

"(b) There are hereby authorized to be appropriated the sums of $12,000,000 in the fiscal year ending June 30, 1970; and $20,000,000 for each succeeding fiscal year until and including the fiscal year ending June 30, 1974, to enable the Secretary to carry out the purposes of this section and section 321 of this Act.

"(c) The Secretary shall, after consultation with the National Advisory Committee on Kidney Disease Programs (established pursuant to section 321 of this title), prescribe general regulations and guidelines concerning (1) eligibility of public or nonprofit agencies, institutions, or organizations for grants under this section, (2) determination of costs with respect to which such grants may be made, (3) the terms and conditions under which such grants will be made, and (4) the assurance that all grants are coordinated with

any existing regional plan for a kidney disease program in a particular area.

"(d) There is hereby established in the Department of Health, Education, and Welfare the Office of Kidney Centers, for the purpose of administering sections 320 and 321 of this Act and providing coordination of Federal activities in the prevention and treatment of kidney disease. The Secretary is authorized to appoint a Director and such additional personnel as are required to perform the responsibilities specified in this Act and such additional responsibilities as the Secretary may assign to the Office of Kidney Centers.

"(e) Subject to the regulations and guidelines established pursuant to subsection (c) the Office of Kidney Centers shall assist in establishing kidney center programs. This assistance shall consist of providing information, services, and grants for planning, training, construction, renovation, and percentage contributions toward the operation of kidney centers.

"(f) A 'kidney center' for the purpose of this section means:

"(1) a 'cooperative kidney center' established within or as a part of a medical school or hospital that has demonstrated a high level of professional competence in relevant medical disciplines. The purpose of the kidney center would be:

"(i) to train medical and supporting personnel;

"(ii) to provide transplantation treatment for patients with chronic uremia where this form of therapy is indicated;

"(iii) to provide dialysis treatment when medically indicated in connection with training, research, and transplantation;

"(iv) to engage in research and the development of new techniques;

"(v) to coordinate with and establish appropriate relations with one or more local community dialysis units (described in subsection (f) (2)); and

"(vi) to assure that knowledge and treatment of kidney disease will evolve in a balanced fashion;

"(2) a local 'community dialysis unit' established in conjunction with and in continuing relationship with a 'cooperative kidney center.' The purposes of a community dialysis unit would be:

"(i) to provide a central training and treatment facility for the care of persons having chronic kidney disease;

"(ii) to provide training and supervision to physicians, staff members, and to patients who are candidates for home dialysis;

"(iii) to foster and promote the availability and

wider use of the equipment and techniques of home dialysis.

"(g) The amount of any grant to carry out the purposes of this section shall include:

"(1) 100 per centum of the costs directly related to the training of physicians, staff members, patients, and their families;

"(2) 100 per centum of the costs for construction or renovation of existing facilities and for the necessary equipment to establish a kidney center under the provisions of subsection (f) (1);

"(3) 60 to 90 per centum of the costs for construction or renovation of existing facilities and for the necessary equipment to establish a community dialysis unit under the provisions of subsection (f) (2). The percentage contribution shall be determined on the basis of the economic status of the particular community involved pursuant to guidelines established by the Secretary.

"(4) 90 per centum in the first year of full operation, 60 per centum in the second year, and 30 per centum in the third year and thereafter of the operation and maintenance costs of cooperative kidney centers and community dialysis units established pursuant to this

Act: *Provided, however,* That grants under this subsection may be in lesser amount if the Secretary determines that centers and units are capable of meeting a larger share of costs of operation.

"(h) Three years after the Secretary formally publishes notice in the Federal Register that applications will be received for grants under this section, the President will transmit to the Congress any recommendations he may wish to make concerning the program. In the event that no changes are made in the authorizing legislation, the program shall continue as authorized under this section and section 320.

"THE NATIONAL ADVISORY COMMITTEE ON KIDNEY DISEASE PROGRAMS

"SEC. 320. (a) There is hereby authorized a National Advisory Committee on Kidney Disease Programs. The Committee shall consist of four members currently in Government service and eight members, not otherwise in the employ of the United States, appointed by the Secretary and with regard to the civil service laws, who are leaders in the fields of the basic medical sciences related to kidney disease, kidney disease diagnosis and treatment, community health programs, or public affairs.

"(b) Each appointed member of the Committee shall hold office for a term of four years, except that any member

appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term and except that the term of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the end of the third year after the date of appointment. An appointed member shall not be eligible to serve for more than two terms.

"(c) Appointed members of the Committee while attending meetings or conferences thereof or otherwise serving on the business of the Committee shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

"(d) The Committee shall advise and assist the Secretary in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this section insofar as it pertains to kidney disease, or the diagnosis, treatment, and care of patients suffering from such diseases. After the Committee is established, it shall con-

sider all applications for grants under section 320 which pertain to kidney diseases, or the diagnosis, treatment, and care of patients suffering from such diseases and shall make recommendations to the Secretary with respect to approval of application for the amounts of such grants.

"(e) The Committee shall also review and make recommendations on kidney disease programs of departments and agencies of the Federal Government, including, but not limited to, those in the Veterans' Administration, the Public Health Service, and the Vocational Rehabilitation Administration, so that the methods, facilities, and programs of these administrative agencies can best be utilized in supporting programs for prevention and treatment of kidney disease. Particular attention shall be paid to the coordination of activities of these various agencies in a given region so as to insure adequate geographical distribution of services and avoid duplication of facilities and services."

SEC. 3. The head of each department, agency, and instrumentality of the United States is authorized and directed to cooperate with the Secretary of Health, Education, and Welfare, to the maximum extent possible, in carrying out the provisions of this Act.

SEC. 4. Except as otherwise specifically provided by any amendment made by this Act, there is authorized to be ap-

propriated such sums as may be necessary to carry out the provisions of this Act.

SEC. 5. The foregoing provisions of this Act shall become effective as of the first day of the first month which begins after the date of enactment of this Act.

91ST CONGRESS
1ST SESSION

S. 2482

IN THE SENATE OF THE UNITED STATES

JUNE 25, 1969

Mr. JAVITS (for himself, Mr. JACKSON, Mr. MAGNUSON, Mr. YARBOROUGH, Mr. AIKEN, Mr. BENNETT, Mr. BIBLE, Mr. BURDICK, Mr. CANNON, Mr. CHURCH, Mr. CRANSTON, Mr. DODD, Mr. EAGLETON, Mr. FANNIN, Mr. GOODELL, Mr. GORE, Mr. GRAVEL, Mr. HARRIS, Mr. HART, Mr. HATFIELD, Mr. HOLLINGS, Mr. HUGHES, Mr. INOUYE, Mr. MCCARTHY, Mr. MCGOVERN, Mr. METCALF, Mr. MILLER, Mr. MONDALE, Mr. MOSS, Mr. MURPHY, Mr. MUSKIE, Mr. NELSON, Mr. PELL, Mr. PROUTY, Mr. RANDOLPH, Mr. RIBICOFF, Mr. SCHWEIKER, Mr. SCOTT, Mr. YOUNG of North Dakota, and Mr. YOUNG of Ohio) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act so as to add to such Act a new title dealing especially with kidney disease and kidney-related diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "National Kidney Disease Act of 1969".

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DECLARATION OF POLICY

SEC. 2. (a) The Congress hereby finds and declares that—

(1) One of the major problems facing medicine and the public health and welfare is the lack of trained individuals, available facilities, research and equipment for the diagnosis evaluation, treatment, and prevention of kidney disease.

(2) No parallel situation in medicine exists today where techniques have been developed for the diagnosis and prevention of disease which would save lives, and yet, at the same time, people continue to progress to chronic kidney disease and death only for the lack of facilities for diagnosis and treatment.

(3) Basic research is needed into the nature of diseases of the kidneys and the problems of kidney transplantation; in developing mass testing procedures for the early detection of kidney disease; and for the development of more effective and economical devices for blood purification.

(4) There is an urgent need for the implementation of a comprehensive program to combat kidney disease through the combined and correlated efforts of the Federal Government and State and local governments, medicine, universities, nonprofit organizations, and individuals.

(b) It is therefore the purpose of this Act to amend

the Public Health Service Act so as to establish a special program to combat kidney disease.

AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

SEC. 3. (a) The Public Health Service Act (42 U.S.C., ch. 6A) is amended by adding at the end thereof the following new title:

"TITLE X—EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELD OF KIDNEY DISEASE

"PURPOSES

"SEC. 1000. The purposes of this title are—

"(a) through grants, to encourage and assist in the establishment of cooperative arrangements among medical schools, research institutions, and hospitals, for research and training (including continuing education) and for related demonstrations of patient care in the field of kidney disease;

"(b) to afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of kidney disease; and

"(c) by these means, to improve generally the health manpower and facilities available to the Nation,

and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 1001. (a) There are authorized to be appropriated $8,000,000 for the fiscal year ending June 30, 1970, $11,000,000 for the fiscal year ending June 30, 1971, $17,000,000 for the fiscal year ending June 30, 1972, $18,000,000 for the fiscal year ending June 30, 1973, and $20,000,000 for the fiscal year ending June 30, 1974, for grants to assist public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies in planning, in conducting feasibility studies, and in operating pilot projects for the establishment, of cooperative medical programs of research, training, and demonstration activities for carrying out the purposes of this title. Sums appropriated under this section for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made. For any fiscal year, such portion of the appropriations pursuant to this

section as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this title.

"(b) A grant under this title shall be for part or all of the cost of the planning or other activities with respect to which the application is made, except that any such grant with respect to construction of, or provision of built-in (as determined in accordance with regulations) equipment for, any facility may not exceed 90 per centum of the cost of such construction or equipment.

"(c) Funds appropriated pursuant to this title shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent it is, as determined in accordance with regulations, incident to those research, training, or demonstration activities which are encompassed by the purposes of this title. No patient shall be furnished hospital, medical, or other care at any facility incident to research, training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician or, where appropriate, a practicing dentist.

"(d) Grants under this title to any agency or institution, or combination thereof, for a cooperative medical program

may be used by it to assist in meeting the cost of participation in such program by any Federal hospital.

"DEFINITIONS

"SEC. 1002. For the purposes of this title—

"(a) the term 'cooperative medical program' means an arrangement among a group of public or nonprofit private institutions or agencies engaged in research, training diagnosis, and treatment relating to kidney disease; but only if such group—

"(1) is situated within a geographic area, composed of any part or parts of any one or more States (which for purposes of this title includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands), which the Secretary determines, in accordance with regulations, to be appropriate for carrying out the purposes of this title;

"(2) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

"(3) has in effect cooperative arrangements among its component units which the Secretary finds will be adequate for effectively carrying out the purposes of this title.

"(b) the term 'medical center' means a medical school or other medical institution involved in post-graduate medical training and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

"(c) the term 'clinical research center' means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

"(d) the term 'hospital' means a hospital as defined in section 625(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this title.

"(e) the term 'nonprofit' as applied to any institution or agency means an institution or agency which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(f) the term 'construction' includes alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (includ-

ing initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"GRANTS FOR PLANNING

"SEC. 1003. (a) The Secretary, after consultation with the National Advisory Council on Kidney and Kidney-Related Diseases established by section 1005 (hereinafter in this title referred to as the 'Council') is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist them in planning the development of cooperative medical programs.

"(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such application may be approved only if it contains or is supported by—

"(1) reasonable assurances that Federal funds paid pursuant to any such grant will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder;

"(2) reasonable assurances that the applicant will provide for such fiscal control and fund accounting pro-

cedures as are required by the Secretary to assure proper disbursement of and accounting for such Federal funds;

"(3) reasonable assurances that the applicant will make such reports, in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

"(4) a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and the institutions and agencies participating in the resulting cooperative medical program) in formulating and carrying out the plan for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program and members of the public familiar with the need for the services provided under the program.

"GRANTS FOR ESTABLISHMENT AND OPERATION OF COOPERATIVE MEDICAL PROGRAMS

"SEC. 1004. (a) The Secretary, after consultation with the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist in the establishment and operation of cooperative medical programs, including construction and equipment of facilities in connection therewith.

"(b) Grants under this section may be made only upon application therefor approved by the Secretary. Any such application may be approved only if it is recommended by the advisory group described in section 1003(b)(4) and contains or is supported by reasonable assurances that—

"(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) will not supplant funds that are otherwise available for establishment or operation of the cooperative medical program with respect to which the grant is made;

"(2) the applicant will provide for such fiscal

control and fund accounting procedures as are required by the Secretary to assure proper disbursement of and accounting for such Federal funds;

"(3) the applicant will make such reports, in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

"(4) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"NATIONAL ADVISORY COUNCIL ON KIDNEY AND KIDNEY-RELATED DISEASES

"SEC. 1005. (a) The Secretary shall appoint, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, a National Advisory Council on Kidney and Kidney-Related Diseases. The Council shall consist of the Surgeon General and sixteen members, not otherwise in the regular full-time employment of the United States, who are leaders in the fields of fundamental sciences, the medical sciences, or public affairs. The members of the Council shall, by majority vote, elect a Chairman and a Vice Chairman of the Council. At least two of the appointed members shall be practicing physicians and at least three of such members shall be outstanding in the study, diagnosis, or treatment of kidney disease or kidney-related diseases.

"(b) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the

fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms.

"(c) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem allowance, as provided in section 5703, United States Code, for persons in the Government service employed intermittently.

"(d) The Council shall advise and assist the Secretary in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council shall consider all applications for grants under this title and shall make recommendations to the Secretary with respect to approval of applications for and the amounts of grants under this title.

"REGULATIONS

"SEC. 1006. The Secretary, after consultation with the Council, shall prescribe general regulations covering the terms and conditions for approving applications for grants under this title and the coordination of programs assisted under this title with programs for training, research, and

demonstrations relating to kidney disease or kidney-related diseases assisted or authorized under other titles of this Act or other Acts of Congress.

"INFORMATION ON SPECIAL TREATMENT AND TRAINING CENTERS

"SEC. 1007. The Secretary shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of kidney disease or kidney-related diseases, together with such related information, including the availability of advanced specialty training in such facilities, as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other information most useful, the Secretary shall from time to time consult with interested national professional organizations.

"REPORT

"SEC. 1008. On or before June 30, 1973, the Secretary, after consultation with the Council, shall submit to the President and to the Congress a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, (2) an ap-

praisal of the activities assisted under this title in the light of their effectiveness in carrying out the purposes of this title, and (3) recommendations with respect to extension or modification of this title in the light thereof.

"RECORDS AND AUDIT

"SEC. 1009. (a) Each recipient of a grant under this title shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

"(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access, for the purpose of audit and examination, to any books, documents, papers, and records of the recipient of any grant under this title which are pertinent to any such grant.

"PROJECT GRANTS FOR MULTIPROGRAM SERVICES

"SEC. 1010. Funds appropriated under this title shall also be available for grants to any public or nonprofit private agency or institution for services needed by, or which will

be of substantial use to, any two or more cooperative medical programs."

(b) (1) Section 1 of the Public Health Service Act is amended to read as follows:

"SECTION 1. Titles I to X, inclusive, of this Act may be cited as the 'Public Health Service Act'."

(2) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title X (as in effect prior to the enactment of this Act) as title XI, and by renumbering sections 1001 through 1014 (as in effect prior to the enactment of this Act), and references thereto, as sections 1101 through 1114, respectively.

(c) Section 431 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(c) The Secretary shall establish, within the Health Services and Mental Health Administration, an Office on Kidney Disease and Kidney-Related Diseases. All of the functions of the National Institutes of Health relating to kidney disease or kidney-related diseases shall be performed by such Office."

The CHAIRMAN. This country must enter an important new era in the struggle against disease. The last decade has seen tremendous advances in research on the nature of disease processes and means for preserving and extending life. Now we are determined that all Americans shall reap the benefits of these advances.

We must move effectively to insure that all Americans do secure high quality health care.

We must improve efficiency so that it may be done at a cost which bears a reasonable relationship to the benefits received.

To do this, we must reduce fragmentation in health care, but we must do so in a way that will not reduce its quality.

We want to extend health care to people, but we must not reduce the quality. We need to raise standards of care, not lower them.

An important national program was initiated in 1965 which shows great promise of dealing effectively with the problem of fragmentation. The program arose, out of recommendations of a Presidential Commission chaired by the eminent heart surgeon, Dr. Michael DeBakey—who is with us today.

The Commission, after pointing out the importance of heart disease, cancer, and stroke as major causes of death and disability in this country, emphasized the need for efforts to promote the application of new knowledge arising from our extensive biomedical research effort.

To achieve this objective, the Commission recommended a pattern of regionalization which would promote the rapid diffusion of new knowledge and skills to help physicians treat patients more effectively.

After examining the means for achieving outreach from the medical centers in order to bring the latest advances in diagnosis and treatment to patients, the Congress in 1965 passed a law, Public Law 89–239, establishing the regional medical programs. Senator Lister Hill was chairman of this subcommittee at that time. I had the privilege of sitting with him and hearing the evidence on which that law was based and passed.

Emphasis was placed on the development of cooperative arrangements among the providers of health care to improve the quality and availability of care.

The law gave full recognition to the role of the medical center in promoting the application of improvements in methodology of health care; it gave equal recognition to those on the firing line—the doctors and other health personnel engaged in providing care who must be actively involved both in the planning and the carrying out of the program to improve care.

This involvement of the various elements of the health care system in this program is significant. For example, some 2,600 institutions and organizations are participating in regional medical programs—all of the medical schools in America; all of the State health departments in the Nation; all of the State affiliates of cancer and heart associations; all of the State medical societies; and over 800 hospitals are involved in operational projects.

All regional medical program activities authorized under the present legislation are concerned with heart disease, cancer, stroke, and related diseases. Heart disease, cancer, and stroke are the leading causes of death in the United States. Together, these diseases ac-

counted for well over 1 million deaths in 1969, more than 70 percent of the deaths in the United States last year.

My new legislation will extend the boundaries of the regional medical programs mandate beyond the diseases originally specified, to include kidney disease, specifically, and all "other major diseases and conditions."

This specific inclusion reflects a growing concern over the national status of kidney disease, which has affected nearly 8 million persons in the United States. About 60,000 of these afflicted individuals will die each year if life-sustaining treatment is not made available to them.

Kidney disease ranks as the fourth cause of death in the United States, and it is a chronic disease that tends to strike in the middle, most productive years of life.

My bill also increases the appropriation authorizations over the next 5 years from $120 million in 1970 to $250 million in 1975.

I am doing this to continue the drive of the initial momentum of these programs and to maintain the commitment of the many health interests and groups that have become involved.

We have a long way to go in the delivery of health care to this Nation; I believe that enactment of this legislation will be a major element in overcoming the fragmentation in our health care system.

We have the greatest medicine in the world. We have the greatest know-how in medicine in the world. But, we have not brought health care to the American people.

That is shown by the fact that a male child born in America today will live an average shorter life than a male child born in 22 other nations.

A female child born in the United States today will live a shorter average life than a female child born in 11 other nations.

In the infant mortality field, there are 15 nations in the world with a better record than ours. Some of theirs are only half as bad as that of the United States. We have slipped backward. Fifteen years ago we were not in that position. Fifteen years ago we were not down to 22d place in the average life expectancy of a male child born in the United States. We have greatly increased our medical knowledge.

But other nations have progressed faster than we in getting this knowledge out to the people. That is where our system has failed greatly.

Therein is where we need health care for the people of the country.

I call on the distinguished ranking minority party member—the distinguished senior Senator from New York, Senator Javits.

Senator JAVITS. Thank you, Mr. Chairman. I congratulate the chairman on a very fine piece of legislation. I am also very pleased that the administration has seen fit to offer its prescription for the problems which the chairman has so very eloquently described and about which he feels so very deeply.

Yesterday, I had the honor to introduce on behalf of the administration, S. 3443, with the cosponsorship of Senators Prouty, Murphy, Dominick, and Saxbe, who are all the members of this Health Subcommittee, and with Senator Scott, the minority leader; Senator Brooke, Senator Goodell, and Senator Schweiker of Pennsylvania, a member of the full committee, who will be testifying this morning.

The bill proposes to broaden the focus of the regional medical

program beyond the original focus on heart disease, cancer, and stroke. It would include kidney disease and other diseases afflicting mankind.

Dr. Egeberg will testify this morning upon this measure which was in contemplation when he prepared his testimony but is now actually introduced.

I shall not trouble the Chair or witnesses with the details, all of which were introduced before the Senate yesterday, except to ask unanimous consent for two purposes, Mr. Chairman: One, to introduce at this point a description of S. 3443, which I have introduced and, second, to ask unanimous consent of the Chair to allow me to distribute S. 3443 to the witnesses and other interested parties and to allow their comments upon the measure should they wish or choose to make any, to be included as part of the hearing record. In view of the fact that the bill was not available until this morning, the witnesses could not directly testify to it, except Dr. Egeberg who, obviously, had a hand in the preparation of the bill.

The CHAIRMAN. The request is granted. Of course, I have difficulty in seeing how witnesses could knowledgeably comment on a bill that they have never seen. The hearings were called some days ago.

The measure you offer, Senator Javits, was just introduced yesterday. I haven't had an opportunity to see it. I notice that Dr. Egeberg is testifying about the administration proposal.

Senator JAVITS. Mr. Chairman, I had that much in mind in my unanimous consent. I am asking leave to distribute this so that they may study it and, in writing, add to the record.

Dr. Egeberg does deal with this measure in his testimony beginning at page 6.

Second, Mr. Chairman, I am extremely pleased with and very strongly in favor of the remarks of the chairman in his introduction of this bill to improve and extend the regional medical program.

I am especially pleased that he included the kidney disease program, which I authored and sponsored as S. 2482, with the chairman, and Senators Magnuson and Jackson and 39 other Senators of both parties.

So I see, as is always true, in the overwhelming majority of cases, there is a real paralleling of interest.

I express the hope that the input of the administration's legislative proposal will be welcome and that the result will be a program which will profit from the Chair's initiative and the willingness of the administration, itself, to come forward with its concept of the best way in which to obtain the result which we seek.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Javits.

Yes, I cosponsored the bill which you introduced to include kidney diseases in the comprehensive bill.

I will now call on a distinguished member of this committee, Senator Schweiker, U.S. Senator from Pennsylvania.

We welcome you to this committee. We know you are very concerned with the problem.

STATEMENT OF HON. RICHARD S. SCHWEIKER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator JAVITS. Mr. Chairman, could I apologize to Senator Schweiker? We have another meeting which I must attend. I will certainly read his testimony.

Senator SCHWEIKER. Thank you.

Mr. Chairman and members of the Subcommittee on Health: I am pleased that your subcommittee has begun hearings on Chairman Yarborough's bill, S. 3355, the Heart Disease, Stroke, and Kidney Disease Amendments of 1970.

As a cosponsor of S. 2482, the National Kidney Disease Act of 1969, I am extremely interested in the legislation now before the subcommittee.

This bill, S. 3355, would make worthwhile changes in the regional medical program. I am pleased that this legislation explicitly adds "kidney disease" to heart disease, cancer, and stroke as one of the diseases to which the program is specifically addressed.

I, too, want to compliment the chairman for his leadership in this area.

Prevention and rehabilitation would be stressed in this bill as well as diagonsis and treatment. Increased research in this field is making possible much more preventive activity, and Federal programs must keep pace.

S. 3355 would also give additional emphasis to the regionalization of health care resources and services. It extends the regional medical program for a 5-year period beginning in fiscal year 1971.

The administration has just proposed its own legislation in the field, and I am pleased to be a cosponsor of this legislation. I am sure that Dr. Egeberg will elaborate more fully on the features of this legislation in his testimony before this subcommittee.

Briefly, the administration's bill combines four programs: the regional medical programs, comprehensive health care planning, the national center for health services research and development, and the national center for health statistics.

This legislation would unite these Federal resources toward the ultimate goal of a new health care delivery system.

It is clear that the States are not handling and probably cannot handle alone the problems resulting from these diseases, without Federal help.

In the case of kidney disease, there is no Federal program to provide kidney hemodialysis equipment for widespread treatment among the general public. Some Federal funds are used for kidney treatment, but only through programs serving special categories of the population. Veterans hospitals are one example.

In the Commonwealth of Pennsylvania, for example, the medicaid program, called Pennsycare, is paying a portion of dialysis treatment costs in selected cases. The Pennsylvania vocational rehabilitation program is available to qualified kidney disease patients, but this support is mainly to help the patient go back to work. It does not adequately cover actual hemodialysis treatment.

These programs are clearly not sufficient to deal with a chronic disease which afflicts about 8 million Americans and kills about 60,000 each year.

I have a personal interest in this legislation. Four weeks ago, Albert W. Cozzie, a long-time neighbor and friend from my home in Lansdale, Pa., died of heart failure at the age of 42. He also suffered from chronic kidney disease.

I visited Al 2 weeks before his death on January 18 at Abington Memorial Hospital, outside of Philadelphia. Abington Hospital has two kidney machines that can serve from 12 to 15 people suffering from end-stage kidney disease each week. The program at Abington Hospital is the only such program available in eastern Montgomery and lower Bucks County in Pennsylvania.

While visiting Al, I had a firsthand opportunity to actually witness the hemodialysis treatment, a treatment which he required three times a week to clear his blood and keep him alive. During my visit with him, Al was very enthusiastic about the treatment.

Projected over a year, the treatment he received at Abington Hospital would cost approximately $20,000. He had planned to purchase one of the $3,000 machines for his home which would cut the cost to about $8,000 a year.

However, Al was employed as a maintenance technician. Like many others in his condition, he was hard-pressed to meet the costs of this expensive treatment.

This is the hardest statistic of all to accept—the fact that 8,000 people die needlessly each year merely for lack of money. These 8,000 were candidates for treatment by kidney transplant or the dialysis treatment. But only 450 patients received transplants and 550 began artificial kidney treatments last year.

So, for every eight patients who could be returned to normal lives through life saving treatments, seven die. Most weekly treatments on a hemodialysis machine cost about $550 and this is the bare minimum of treatments. Most kidney disease patients should have three treatments of 10 hours each a week in order to keep them in normal health. Hemodialysis machines, as I mentioned earlier, cost from $3,000 to $6,000.

However, they are not readily available on the market and the maintenance cost on this machine is in excess of $50 per week. Also, a trained attendant must be available.

Clearly, Federal money must be found to help people in a situation like this, and my visit with Al Cozzie certainly dramatized this need for me. Each week in the mail I receive additional letters from kidney disease patients seeking my help.

Many community groups in Pennsylvania regularly write to tell me of their fund-raising activities for a kidney patient in the community who needs dialysis equipment.

The United Steel Workers of America is squarely behind the new kidney legislation.

In recent years, public awareness of kidney disease has greatly increased and it has become a matter of utmost concern for Federal and private research efforts.

Also, increased interest in this program has brought about the major development of kidney dialysis techniques, but this is very expensive.

Thus, the passage of S. 3355, the Heart Disease, Stroke, and Kidney Disease Amendments of 1970, will go a long way toward providing the staff, facilities, research, and equipment that are needed.

The CHAIRMAN. Thank you, Senator Schweiker. I congratulate you for having condensed your statement to only three pages, presenting a comprehensive statement that so dramatizes and presents factually the situation in one family and the situation across the Nation caused by this problem. This is very helpful to the committee.

Senator SCHWEIKER. Thank you very much, Mr. Chairman.

The CHAIRMAN. The next witness is Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare.

STATEMENT OF DR. ROGER EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. JESSE L. STEINFELD, DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; AND DR. JOSEPH T. ENGLISH, ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Dr. EGEBERG. Mr. Chairman and members of the committee: I thought I might speak informally about what I have to say. What we are really doing is in full recognition of what you are suggesting, and we are in wholehearted agreement with it.

We would hope that we might combine in a working arrangement, but not as one, two other very important programs in the delivery of health care in these days when perhaps 30, 40 or 50 bills and laws on health care have been considered during the last 3 or 4 years. We need to bring together some of them in a better working arrangement.

I am pleased to have the opportunity to discuss with you the administration's proposal, S. 3443, that Senator Javits mentioned, for extending and improving the regional medical programs and other related programs central to our efforts to improve the organization and delivery of health services in the Nation.

I will also comment on the proposed legislation extending the regional medical programs introduced for himself and other members of the committee by the distinguished chairman, Senator Yarborough.

As you know, Mr. Chairman, health is a basic right in our society. Yet, in spite of our knowledge of health, in spite of our sophisticated technology and in spite of our vast material resources, we have a crisis in health care in this country.

In his July "Report on the Health of the Nation's Health Care System," Secretary Finch challenged this Department, and indeed the Nation, to use all of its available resources "to put into motion initiatives that ultimately will reshape the system." He said:

> Faced with this extremely difficult situation, we nevertheless cannot abandon our national goal of effective and dignified health care for every American no matter what his station in life or where he lives. We cannot accept anything less in this the most affluent society in the world. As long as there are people in this country who are denied essential health services because of poverty, or race, or lack of access for any reason, we have fallen short of our promise as a nation.
>
> This country has made achievements in the quality of care beyond anything that could have been imagined at the turn of the century. It is that very success that has brought us to the present test of whether we have the capacity to extend that same quality of care to all in society at a price which they can afford. What is ultimately at stake is the pluralistic, independent, voluntary nature

of our health care system. We will lose it to pressures for monolithic government-dominated medical care unless we can make that system work for everyone in this Nation.

The proposal we are making today represents an important initiative by the Federal Government designed to improve the quality and availability of health care in our Nation.

The proposal is based on several assumptions about any Federal effort directed toward improving the organiaztion and delivery of health services:

First. Existing Federal health efforts represent about one-quarter of the Nation's $60 billion health industry. All public expenditures represent better than one-third of the total. While the absolute size of the public investment in health is likely to increase, the proportion of the total national effort which it represents will probably remain relatively stable over the next few years. Despite the apparent size of public expenditures, the American health system is still essentially a private system.

Second. There must be a dynamic, effective partnership among those in the private sector who provide health and medical services, government at all levels, and the consumers of health services if maximum effectiveness and efficiency in the delivery of health care are to be achieved.

Third. While there are now several separate Federal efforts directed to different aspects of the organization and delivery of health care, they must be better coordinated and more closely integrated.

Fourth. Federal assistance should be provided to cooperative efforts among public and private agencies and institutions at all levels for the development of more effective and efficient health care delivery systems.

Against this background, the Department is taking specific steps to help solve the major problems of building better consumer-oriented health care systems. Some of these steps affect the financing of health services.

The proposed Health Cost-Effectiveness Amendments of 1969 and the preliminary recommendations of the medicaid task force, for example, are intended to improve the effectiveness of health care financing mechanisms.

We recognize fully that improvements in financing are only a partial response to the problems of effective health services for all.

We also need to improve substantially the way our health care resources are organized and our health services delivered if they are to meet adequately the growing demands now being placed on them. Fortunately, we have already made a beginning.

The three major programs covered by this legislation—regional medical programs, comprehensive health planning and services program, and health services research and development—fill important gaps in our health system. Each is aimed at a particular need.

While they are still in early stages of devlopment, these programs have already engaged the institutions, organizations and individuals whose active participation and support are essential for the tasks ahead.

The proposal we are making today will not only continue but strengthen the legislative base for these programs. The proposed bill goes beyond a simple extension of existing authorities.

The programs are included in a single title of the Public Health Service Act with an overall statement of purpose which gives a clear indication of the common objectives toward which they are directed.

To insure that these common objectives are carried out, a single advisory council is established which will provide advice and recommendations to the Secretary on the implementation and coordination of these programs.

The intensive experiments and demonstrations in health care system building which we intend to carry out underscore our intention to mount a more coherent and vigorous attack on the problems of our fragmented health care system—using all the means at our disposal.

A single annual report of progress under these programs will be required, a report which will provide detailed information on how effectively these programs are meeting the challenge of health care system building.

Through this legislation the Department will be able to give a renewed sense of purpose and direction to those efforts to improve the health care delivery system which are already underway, by capitalizing on the unique strengths of each of the existing programs.

At the same time, we intend to focus special efforts and funds on selected experimental situations which promise more effective and efficient delivery of health care.

These experiments will be used to identify the best ways of using the existing programs to improve systems of health care and yield a greater return on our health dollars. They will be carefully designed to provide knowledge about effective health system organization and to provide a variety of demonstrated models of improved health services for utilization in other parts of the country.

The experiments will also provide a better basis for further modification, in the coming years, of the health programs we are discussing today.

The experiments will involve not only the health programs authorized in this bill, but also other Federal, State, and local health programs and sources of health care financing.

In particular, we intend to coordinate these activities with related programs authorized by the Social Security Act, especially the maternal and child health program, the medicaid demonstrations and the medicare incentive reimbursement experiments.

The proposed National Advisory Council is specifically designated to advise the Secretary of Health, Education, and Welfare on the coordination of these programs with other Federal and federally assisted health programs, giving particular attention to the relationship between the organization and delivery of health services and the financing of such services.

Finally, the proposal requires that the Secretary give the Congress an annual report on improvements in the efficiency and effectiveness in the delivery of health services accomplished under the bill, including a statement of the relationship between these programs and financing arrangements authorized by the Social Security Act.

Here, Mr. Chairman, are the highlights of the proposed legislation. The bill provides a new title IX in the Public Health Service Act which would include 3-year authorizations for comprehensive health planning and services—now authorized by section 314—for regional medical

programs, for health services research and development—now authorized by section 304—and for the initial steps in developing a Federal-State-local health information and statistical system.

The bill provides a single statement of purpose which augments the purposes of the individual programs and makes clear their interrelationships in improving health services.

It authorizes a new National Advisory Council on the Planning, Organization, and Delivery of Health Services which will provide policy advice and specific recommendations to the Secretary on the administration of these programs and will provide policy guidance for the selected experiments and demonstrations to be developed.

The scope of the regional medical programs is broadened beyond the original focus on heart disease, cancer and stroke to permit support of a wider range of activities related to the organization and quality of health services.

The bill would facilitate local coordination of regional medical programs and comprehensive health planning agencies by requiring official health planning agency representation on RMP regional advisory councils, and RMP representation on State and local planning councils.

It would provide for areawide health planning agency review and comment on applications for health services development grants, and similar opportunity to both State and areawide agencies on regional medical program activities.

It also provides for joint funding of projects and for the transfer of a limited portion of the funds between programs when this is essention to the accomplishment of the purposes of the bill.

Mr. Chairman, we view this proposal as an essential initiative to improve the coordination of the Department's health programs and to help meet the urgent need for improved health care for the Nation.

By highlighting the progress of the programs included in the proposed Health Services Improvement Act of 1970, I want to emphasize that the accomplishments of these programs have been substantial.

We expect to capitalize on these achievements as we focus more intensively on the development of better systems for the organization and delivery of health services.

First, let me briefly review the regional medical programs.

Although there has been a rapid rise in public expenditures for health services, the provision of medical care remains largely within the private sector.

Over three-quarters of personal health care is provided by private physicians, private group practices, voluntary hospitals, and clinics.

When governmental agencies set out to encourage changes which affect the private sector, the effort should be carefully designed to encourage participation and cooperation in the change process of those affected.

Since, to a very large extent, we are dependent for the provision of health care on existing resources—physicians, hospitals, and all other health professionals and institutions—we intend to take actions which assure their active and constructive involvement in any attempt to improve the system.

We are committed to change through and with these resources and not in spite of them. Certainly we do not intend to hamper the effectiveness of participants in the system, but, rather, to enhance it.

The unique advantage of the regional medical programs is their ability to improve the quality and availability of health services by enlisting the support of the private sector. Over the 5 years since the programs were first authorized, they have shown significant potential for bringing about change through the development of cooperative arrangements among the principal providers and consumers of health care services at the regional level.

Let me describe some of the ways these programs work.

A network of coronary care units has been established in an isolated Appalachian area of western North Carolina, known as the State of Franklin, with financial and technical assistance from the North Carolina RMP.

Eight small hospitals, all with less than 50 beds, have been linked together and to the Bowman-Gray School of Medicine in Winston-Salem, over 100 miles to the east, by a telephone line for the transmission and analysis of electrocardiograms.

Beyond improving coronary care in the State of Franklin, this "network" improves the prospect that the individual participating hospitals may be accredited.

In many regions the RMP assists representatives of the intercity to plan for improved health services; the Watts-Willowbrook section of Los Angeles is a notable example.

The New Jersey RMP has assigned full-time urban health coordinators to the model cities offices of Newark, Trenton, and Hoboken to work with citizens' panels, to help identify priorities for health services, and to develop action proposals as integral parts of the overall model cities plans.

In east Texas, an RMP project has brought high quality stroke rehabilitation to a small, rural town. The Southwestern Medical School in Dallas developed a joint program with the East Texas Treatment Center in Kilgore, a geographically isolated community 125 miles from the medical school. Though the center was modern and the sole rehabilitation facility within a 50-mile radius, it was underutilized.

As a result of the cooperative RMP project, permanent staff and consultative personnel have been added, skills of existing personnel have been upgraded, treatment and rehabilitation techniques have been improved, and it is now likely that the center will become self-sufficient.

The CHAIRMAN. In speaking of Kilgore, you say it is a geographically isolated community about 125 miles from the medical school in Dallas. Kilgore is not exactly what we normally think of when we say Appalachia. It has more oil wells per block than any other city in the world. They are pumping oil out of almost every backyard in the town. It is often photographed for magazines.

Dr. EGEBERG. Thank you. I was not a long-time resident of Kilgore. I thank you for that, because it shows that the regional medical programs are reaching out not only to help in areas where they are very poor, such as some parts of Appalachia, but to the lower middle-class also. Maybe we can move to west Texas.

I want to cite one other illustration of the cooperation of health groups through RMP support. One of the initial actions of the Georgia RMP was to promote the establishment of hospital-based, local advisory groups to identify local needs and problems and to serve as a

local liaison with the region's core staff and the regional advisory group.

There are now 129 such groups in that region with 478 participants, including 127 practicing physicians, 128 hospital administrators, 114 nurses and allied health personnel, and 109 public members.

It is this kind of widespread, grassroots participation in regional medical programs by providers and the public which has enabled it to move ahead quickly and which makes it a promising mechanism for bringing about change in our health care system. The achievements and potential of the regional medical programs warrant wholehearted support of the extension of the authorization.

Senator Yarborough, this Department could concur with a substantial number—in fact, practically all—of the provisions in your bill, S. 3355, if we considered only the regional medical programs.

However, we firmly believe that we can work most effectively with a bill extending not only the regional medical programs, but also the comprehensive health planning and services program, and the health services research and development program—focusing them all on improving our Nation's health care system.

There is a paragraph here that somebody other than I put in here. I don't know that I care to read it. But it says that we oppose the provisions in your recommendations, in your act, which would authorize new construction of demonstration, research, and training facilities. We do this in view of stringent budgets and because we feel that the present laws, the laws covering construction, Hill-Burton, Health Professions Education Assistance Act, and health research facilities, plus other laws, enable us to do most of this building if we can get the money.

The CHAIRMAN. This was put in the bill so it could be keyed into regional medical needs. Of course, Dr. Egeberg, you know of the great cutbacks we have recently experienced in Federal appropriations for medical education and research.

There are many empty rooms in research institutions now existing because of the Federal Government's reduction of moneys for medical research. It has curtailed investiagtion and research, particularly in in the field of cancer, and caused the facilities which have already been constructed to be left unused.

It is not that there was an overconstruction of facilities but, in my opinion, there was an underutilization of them.

Sixty cents out of every dollar spent on medical education in the United States has been furnished for some years by the Federal Government. As I sit here and think about what you say, you cannot do this without trained medical personnel and trained doctors.

Furthermore, research is the device by which we put money into medical schools.

As you know, two dental schools in the United States have closed their doors in the past year. Three medical schools are faced with closing now. Others are having great difficulty keeping their doors open, despite the great shortage of medical students in the United States today.

I don't think we ought to retrench on research until we have certainly found the cause and cure of cancer. Ten years ago, I was on this subcommittee; and leaders in the field of cancer research said if

this country really wants to find the cause and cure of cancer they can do it, the people have the will to do it.

They said it would take the expenditure of about $1 billion a year and we would have a cure in 10 years. I said I was ready to spend it then. Nobody else said that and it seemed to shock some people.

In that 10 years we have spent $100 billion on the war in Southeast Asia and $25 billion on space research. According to the best medical experts we had at that time, they testified that with $10 billion we would have cancer cured in America today.

So I cannot agree with your opposing the provisions referred to in my bill.

We have had the most knowledgeable testimony in this country before this committee 10 years ago.

We have had some cancer research, but it reminds me of a religious song I used to hear that mercy was dropping around us afalling.

We are still talking about peanuts while we spend $100 billion in Southeast Asia in that period of time.

I just wanted to refer to your opposition to my provision which would refer to demonstration facilities.

Dr. EGEBERG. I think the paragraph has already served a good purpose, sir.

The CHAIRMAN. Thank you.

Dr. EGEBERG. The second major program extended by the proposed Health Services Improvement Act of 1970, is partnership for health.

This program supports comprehensive health planning at the State and community levels, State public health services, health services development projects, and related training.

The proposed bill clarifies the relationship of these activities to the regional medical programs and locates the statutory authority in title IX of the Public Health Service Act.

After less than 3 years of actual experience, the comprehensive health planning program is gaining widespread acceptance as the need for a coordinated approach to health is more widely understood, and as the agencies funded demonstrate that they have a key role to play in developing plans to bring about coordination. We now have comprehensive health planning agencies in 55 States and other jurisdictions—out of 56 eligible jurisdictions.

There are also 113 areawide agencies, of which 11 have already made the transition from the organizational to the operational stage, with 30 more coming into operation within a few months.

The activities of these State and local groups cover the entire range of health interests from jurisdictional planning for diverse geographic areas and political units to developing priority health programs of statewide or multistate scope; from involvement with methods for the treatment of individuals to concern with the State of the environment.

Planning agencies have direct impact upon the delivery of health services in their areas. In Magnolia, Ark., for instance, the agency brought about effective cooperation between two hospitals which had duplicated services and had planned individual expansion. This story can be told over and over again in many areas.

In Minnesota, the State agency conducted a study of residential care which stimulated legislative action, including State reimbursement of counties for residential placement of retarded children and

the development of State hospitals as multipurpose regional centers.

On the basis of study recommendations made by the New Hampshire CHP Advisory Council, courses to prepare students for several health occupations will be in the curriculum of the New Hampshire Vocational and Technical Institute next year.

A variety of training programs are expanding our health planning capabilities. Approximately 250 students in 18 graduate training programs are working toward degrees in health planning. In 1969, 520 professionals and 674 consumers were offered some form of special training.

Encouraging changes are also taking place in the way States are using bloc grants for comprehensive health services, not only to continue existing categorical programs but also to develop new systems and methods for the delivery of health services, especially to high-risk groups like the poor.

Significant differences are also emerging in the 1970 State comprehensive health plans. States are focusing on specific priorities. Vermont and New York, for example, place major emphasis on home health services.

West Virginia gives high priority to statewide expansion of family planning, environmental health, and dental health services.

New Mexico reflects some redirection toward suicide prevention, drug abuse, and integrated mental health services.

And some States are now distributing more funds to local health jurisdictions.

Project grants for health services development, another part of the "partnership" program, are a flexible tool for responding quickly to new challenges and for developing innovative health services; for example, prevention of a German measles epidemic, rat control in cities, or comprehensive health service programs.

While we encourage a variety of activities, we emphasize programs which (1) assure accessible ambulatory care, (2) incorporate sound preventive health measures, (3) provide total family care, and (4) insure continuity of care—prevention, diagnosis, treatment, and rehabilitation.

These illustrations of progress made through the partnership for health program argue persuasively for extending the authorization and indicate the contribution these programs can make to the development of more effective health care systems.

A major new thrust of the proposed Health Services Improvement Act of 1970, Mr. Chairman, is to undertake intensive experiments to develop a set of models for fully effective, consumer-oriented health care systems.

To do this, special resources will be made available to half a dozen to a dozen areas for health care system building.

These experiments will be carried on jointly through volunteer local RMP and CHP agencies with cooperation, technical assistance, and financial support from the Federal Government.

RMP and CHP agencies in some places are already engaged in joint efforts. For example, the Upper Kennebec Valley Regional Health Agency, in Waterville, Maine, has become the areawide health planning agency for the same subregion for which it carries out RMP planning functions.

With a combination of RMP, DOT, and local funds, the agency also directs a home health care service, a regional blood bank, and operates an emergency care transportation and communications division.

Similiarly, the Colorado State CHP agency, the health department, and the regional medical program, assisted by the American Public Health Association, are jointly funding a study of public health services in the State.

In Worcester, Mass., an areawide agency and the RMP have undertaken a joint study of stroke, radiotherapy, coronary care, and chronic pulmonary care.

The areawide agency in Metropolitan St. Louis is working with local consumer and provider organizations to develop badly needed ambulatory care programs.

What I am saying here implies that we are not only initiating, but also responding to efforts throughout the country to bring together the working forces of these groups.

The CHAIRMAN. I think, Dr. Egeberg, your testimony is an eloquent testimonial to the success of the comprehensive health planning services program and the health services research and development program.

As I take it, these are success stories you are reading here which have come from the creation of those agencies in your department.

Dr. EGEBERG. I don't mean to be doing that, but I am trying to bring forth the picture across the country.

The CHAIRMAN. Giving us the facts, though, will help us in forming the legislation. When you put them together, it is pretty encouraging. We have a lot of testimony here on how bad things are, but this shows, though in a limited way, that there are many steps in the right direction.

To date there are 113 areawide agencies, 11 in operational stages, 30 more coming into operation in a few months, and 55 jurisdictions with comprehensive health planning agencies. Certainly with that program we are making progress, though perhaps not fast enough. There is real hope for the future.

Dr. EGEBERG. Thank you, sir. And they, out there, have been reaching to try to find some way of working better together.

It is this sort of cooperation which gives us confidence that we can put these existing programs to the larger task of developing effective comprehensive health care systems.

Our proposal is a first careful step toward that broad goal.

We cannot now forecast in exact detail the character and outcome of the experiments since experimental designs and aproaches will, of course, depend upon negotiations with specific States, localities and public and private organizations.

We have in mind, however, some of the following approaches:

One. In relatively small or simple situations, multiple functions could be served by a single RMP–CHP staff, by two staffs and a single board, or by one staff and two boards.

Two. Under a more complicated and dynamic approach an areawide CHP agency could be given community responsibility for structuring the local health care system, including considerable influence over programs and capital funding decisions. The RMP would pro-

vide specialized regional aid, including technical assistance on the development of primary care, training, continuing education, specialized regional services and professional supervision of quality control.

Three. Another model would provide for the assumption of geographic responsibility by community hospitals, extending across all levels of care and concerning the efficiency of the total system rather than the efficiency of acute care only.

Four. Yet another model might experiment with competitive prepaid group practices with various options including the ownership of a hospital.

Five. Another experiment might focus on relationships along a continuum of care—prevention, diagnosis, treatment, and rehabilitation—attempting to distribute responsibility among community institutions for each of these functions and to create the relationships necessary to make it possible for consumers to know how, where, and when they could and should go for various types of treatment and what that treatment will cost.

These health care system experiments will be carefully designed, monitored, and evaluated by HEW and the State, local, and private participants.

We hope to develop a series of models appropriate to varying geographic areas, to carrying demographic conditions, and to areas with different patterns of health care needs and resources.

We have no single model in mind now, nor do we expect to have a single model in the future. Rather, we expect to develop a series of effective models which could, with modifications, be used in appropriate settings throughout the Nation.

In addition to the regional medical programs and partnership for health which I have already discussed, the Health Services Improvement Act of 1970 extends the authority for health services research and development.

It should be clear from my earlier testimony that research and development activities play an integral part in any effort to improve the delivery of health services.

We intend to bring the findings of research and development to bear directly on the design, development, and evaluation of health care systems experiments.

We also plan to devote some of the future health services research and development funds and the outstanding expertise of the national center to the conduct of these experiments.

It is clear to us that we must improve the techniques of applied health services research and that we must establish appropriate experimental methods if we are to establish cause and effect relationships between innovative efforts and apparent health improvements. We must insure that we know enough about successful enterprises to reproduce them.

As you know, Mr. Chairman, despite the problems which plague the Nation's health industry, most health services research and development activities of the past have been spotty, fragmented, uncoordinated and limited to isolated geographic or categorical problems.

Enactment by the Congress of section 304 of the Public Health Services Act in 1967, and establishment of the National Center for Health Services Research and Development in 1968, represented the first clearly focused Federal initiatives in this area.

We now have the vehicle to support applied health services research and development through the type of sustained, concentrated and adequately funded activities which have characterized, for example, the biomedical research programs of the National Institutes of Health.

Might I interject the fact that while the scientific aspects in medicine have doubled, have advanced more since 1940 than in all the history of mankind up until 1940, the delivery of health care is not very unlike what it was during the time of Hypocrates about 3,000 years ago. It is this issue that we need to concentrate on and develop very much at the present time.

We are committed to a bold research and development program to deal with (1) rising costs and inadequate financing methods, (2) unequal distribution and utilization of health services, (3) failures to develop or adopt new technologies for health care and delivery, (4) shortages of professional and paraprofessional personnel, and (5) the need for adequate criteria and methods for evaluating the effectiveness of health services.

With the extension of the authority under section 304, in the context of the Health Services Imrovement Act of 1970, the National Center for Health Services Research and Development will continue its critical role in these priority areas with a new impetus to help improve the organization and delivery of health services.

Finally, Mr. Chairman, the proposed bill amends section 305(a) of the Public Health Service Act to reflect the increasing demand for data on health care resources, environmental and social health hazards, and family formation, growth, and development.

It also establishes authority for the initial steps (research, development, and evaluation) in the development of a cooperative health information and statistics system—a continuing joint endeavor by Federal, State, and local units, based upon comparable definitions, standards, and methods for the collection and processing of data.

The nucleus of a system like this already exists in the area of vital records.

While this system has some technical problems it is, nonetheless, an example of a longstanding cooperative Federal-State-local activity which has provided consistently, ever the years, valuable data for the development of health programs.

Health statistics currently generated by State and local areas are of uneven quality. While many jurisdictions have recognized this problem, they can not remedy the situation on their own.

States and localities which have developed their own data systems may be producing statistics which are not comparable to those of other States or of the Federal Government. The States continue to rely on us for some types of data.

Yet, it would be more reasonable if, in conformance with national standards of uniformity and quality, they could produce detailed data which meet their own needs as well as ours.

We view the joint system as a critical component of our continuing health partnership with the States and communities.

Mr. Chairman, we have given careful thought and study to the proposals contained in the Health Services Improvement Act of 1970.

We made an especially detailed examination of the regional medical programs and the comprehensive health planning programs.

We have had the advice of outside consultant groups, including the initial recommendations of the task force on medicaid and related programs.

Based on these efforts, we are convinced that our proposals will lead to a more productive use of Federal programs and resources, and to a more fully coordinated and systematic approach to organizing and delivering health care.

Our aim, like yours, is to help the American citizen exercise his right to the highest level of care attainable.

I have one additional qualification. I was actively involved in both the regional medical programs and in the establishment of the comprehensive health care planning in the State of California.

Now; my colleagues and I would be pleased, Mr. Chairman, to answer any questions which you and the members of the subcommittee may have.

I thank you very much for allowing me the time to give, in this detail, really, the testimony on two or three possible bills, and for your listening.

Thank you, sir.

The CHAIRMAN. Thank you, Dr. Egeberg. Of course, since the bill to which your testimony was primarily addressed was introduced yesterday and I have not seen it, I am not in a position to address specifically the provisions of that bill.

It does carry forward three measures previously heard by this committee and previously enacted into law. I think probably the most important statement in your statement is that on page 1, reiterated on the last page, where you say, "Health is a basic right in our society." That has not been so recognized in our system in the past. There is a limited form under medicare and medicaid for elderly people, but we have not recognized that health care is everyone's right.

We haven't seen your bill. How much money do you propose to spend on the new legislation?

Dr. EGEBERG. We are adding about $10 million for the initiation of this to the new legislation.

The CHAIRMAN. That would be in addition to what would be spent under the three different programs?

Dr. EGEBERG. That is in addition to the amount that would be requested under each of the programs.

The CHAIRMAN. Would that be more than you asked for in the past?

I learned last year, when I became chairman for the first time of an Appropriations Subcommittee, that the Budget Bureau has no trained health professional or educational professional in the whole Bureau of the Budget.

I take it that is the reason that the Bureau of the Budget cuts the heart out of so many health and education programs while being so solicitous of all military ventures overseas.

I believe there was $75 billion-plus for military and that didn't include military construction. About $58 billion out of $135 billion was for all programs. That is the annual budget.

I do not refer to fixed charges, like $17 billion interest on the debt, social security payments, fixed charges under the law.

The Appropriations Committee appropriated $135.2 billion. But there was $75 billion for the military, with military construction being a separate item.

We have underdeveloped nations and quarrel with them because so much of their budget is military, yet, we put $75 billion out of $135 billion into the military.

Health and education do suffer here at home because of that.

It takes money to buy these facilities, with the increasing cost of living, the runaway inflation. What would that extra $10 million be used for? It is kind of like Alice in Wonderland; you are slipping backward if you ask for the same money asked for the year before.

Dr. EGEBERG. I am still an optimist. I am hoping that I am going to find a pocket that hasn't been touched yet, and I have some ideas of where those pockets may be.

The CHAIRMAN. When you tire of your present job, Doctor, I would like to see you put in the Bureau of the Budget.

Dr. STEINFELD. I can provide the figures for the fiscal 1971 budget among these various programs, if you would like them, either for the record or read them to you now.

The CHAIRMAN. I was speaking now of what we could do with authorizations primarily. I haven't seen your bill which was introduced yesterday. But what does it provide in extensions of these programs tha are expiring, how much money in comparison with the money authorized in the past?

We have to authorize the money before we go after the appropriations.

Dr. ENGLISH. Mr. Chairman, in this particular piece of legislation that Dr. Egeberg was testifying on this morning, the authorization request is for such sums as necessary, and we would be glad to submit to you for the record——

The CHAIRMAN. That suits me all right, but the Members of Congress in the administration's party would probably jump straight out of their seats and say that that was an open-ended authorization.

Dr. ENGLISH. Let me give you the appropriate figures. The 1970 figure for all the programs included within this bill is $329 million, and the 1971 budget request of the President for these bills is $391 million.

The CHAIRMAN. Do you have them broken down for the three programs?

Dr. ENGLISH. Yes, sir. We would be glad to submit that for the record.

The CHAIRMAN. Would you let us see that, please?

Dr. ENGLISH. Yes, sir.

(The information subsequently furnished appears on p. 211.)

The CHAIRMAN. Dr. Egeberg, you referred to 3,000 years ago, to the time of Hippocrates. Was that ad-libbed?

Dr. EGEBERG. That was ad-libbed.

The CHAIRMAN. What exactly was that? It was an intriguing sentence.

Dr. EGEBERG. At the time of Hippocrates, doctors sat on the steps of the temple, the priests with the authority of the Greek gods behind them.

People came and got advice on health care. Medicine is still primarily a come-and-get-it system, and it has been a come-and-get-it system of late, I think, because of the pressure on the doctors.

There are not enough of them to really think about the people who can't come and get it.

So some of the rest of us have to think about that. That is why I say it hasn't changed; it is still a system whereby you put the initiative on the patient to find somebody who can take care of them when they are sick.

We will have to start taking care of them before they get sick, through education. I think we will have to change this come-and-get-it system. That is what we are trying to do.

The CHAIRMAN. Hippocrates built a great hospital, with marble floors, and still had to make a place for the priests and when he cured somebody he had to give the priests credit. If he had not, the religious infrastructure would destroy him. Doctors can take credit themselves today.

Dr. EGEBERG. I think any good doctor will give the Lord credit for the major part of what happens.

The CHAIRMAN. Do you think there is still a good bit of that?

Dr. EGEBERG. I do. I, at least, felt that way when I practiced.

The CHAIRMAN. I want to congratulate you on your statement, your commitment to bold research and development programs that deal with rising costs and inadequate financing methods, unequal distribution and utilization of health services, the failure to adopt new technologies for health care and delivery, the shortages of professional and paraprofessional personnel, and so forth.

I think that is a strong statement of desire and I concur wholeheartedly in that.

Dr. EGEBERG. Thank you, sir.

The CHAIRMAN. On page 24, you speak of the Public Health Service reflecting the increasing demand for data and health care sources, with the environmental and social health aspects.

I know we have given too little attention to that. I have taken part in three symposia in the last 2 weeks, one on water pollution, one on air pollution, and one on destroying the estuarian environment, so rich in prospects for plant life and animal life, where the elements brought down by the freshwater rivers meet the salt water, with great spawning grounds for so many forms of seafood.

I am glad to see you reaching out to study that.

Then there are the instances of smog, cases where after smog has lain on a valley for a while and people are killed.

There is a great need for a great expansion of scientific research and knowledge.

I am advised that some of these people who are engaged to study that have made little study because of a combination of factors.

There is little or no research on what a combination of these elements in the air do to a man's life.

I yield to the distinguished Senator from Iowa, Senator Hughes, a very valued and active member of this committee, and chairman of the Subcommittee on Alcoholism and Narcotics.

Senator HUGHES. Mr. Chairman, I will pass asking any questions because of my late arrival. I will rely on the questions you have asked.

The CHAIRMAN. Dr. Egeberg, we have had no opportunity to read this new legislation. We may have written questions to submit to you before the hearings reach their conclusion.

Looking at this appropriation activity on the chart just handed me, I note where there apparently was an increase in projects grants. It says this includes an increase from $73 million to $109 million.

At first blush, it looks like a $36 million increase. It says this includes $30 million transfer of funds and program responsibilities from the OEO. It wouldn't really be an increase in moneys.

Dr. EGEBERG. No, because we take the projects with it.

The CHAIRMAN. I think we can study these and save your time and mine by having the staff present any questions.

Dr. EGEBERG. I will be happy to return any time you wish.

The CHAIRMAN. Thank you very much.

And thank you, Dr. English and Dr. Steinfeld.

The CHAIRMAN. The next witness is Dr. Michael DeBakey, president of the Baylor College of Medicine in Texas, who is also testifying on behalf of the American Heart Association.

STATEMENT OF DR. MICHAEL DeBAKEY, PRESIDENT, BAYLOR COLLEGE OF MEDICINE, HOUSTON, TEX., APPEARING ALSO FOR AMERICAN HEART ASSOCIATION AND ASSOCIATION OF AMERICAN COLLEGES

Dr. DEBAKEY. Mr. Chairman.

The CHAIRMAN. We are proud to welcome you before this subcommittee. Your testimony before us in years past has had a great influence in the passage of a number of medical laws. You have been in the forefront among practicing teachers and doctors in America, in the forefront for better teachers in America and better service to the people of America.

I am very proud, of course, in representing the State of Texas, that you are a relative of my State, in which great work is being done. We are happy to recognize before this subcommittee one of the great heart surgeons of all time.

Dr. DEBAKEY. Thank you very much, Senator Yarborough.

I would like to first say that I am very grateful and appreciative of the privilege and opportunity to appear before this committee again, now under our new and distinguished chairman. I must say that I am also proud, on behalf of the State of Texas, that we have such a distinguished chairman heading up this very important committee concerned with health activities in this country.

I am especially pleased to talk about this bill and to support S. 3355, Mr. Chairman. I speak on behalf of the American Heart Association and the American Association of Medical Colleges, who also have asked that I speak for them in testifying in support of this bill.

Mr. Chairman, you know, and have already referred to the fact, that I was chairman of the President's Commission on Heart Disease, Cancer, and Stroke, from which this regional medical program legislation has since emanated. Since the inception of the regional medical program was in the Commission and was a very important recommendation made by this Commission in an effort to help control and develop programs for the control of heart disease, cancer, and stroke,

this brings me to a very important aspect of this bill, and an important consideration from a practical standpoint, of the targeted approach to certain specific problems that constitute large problems from a health standpoint of our population.

Heart disease, cancer, and stroke constitute something like 70 percent of all deaths. In that sense, it constitutes a very important aspect of the total health problem. The targeted, specific approach to problems of this kind I think is extremely important. In any disease problem which affects a large segment of our population, it produces a large amount of suffering, disability and death, and these include problems that are in the area of heart disease, cancer, and stroke, and others; diabetes, mental illness, alcoholism. These are all large problems affecting our population and are specific categorical problems. They are not noncategorical diseases. Indeed, Mr. Chairman, in all my experience——

The CHAIRMAN. Pardon me, Dr. DeBakey. I have just had a call from the sergeant at arms, that they are trying to get a quorum. My presence is requested. I had better go to the floor. Senator Hughes will take over the chair in my absence.

Senator HUGHES (presiding pro tempore). Please continue, Doctor.

Dr. DEBAKEY. Senator Hughes, it is a pleasure for me to appear before you, too. I want to express my appreciation for what you have done on this committee in the area of health and program planning.

What I was saying was, I think, the categorical approach to these various disease problems is extremely important. As I indicated, in all my experience as a clinical surgeon, literally dealing with thousands of patients, I have yet to see a patient who suffered or died from a noncategorical disease. They all suffer from these categorical diseases. This is why it is extremely important to maintain, I think, the identity of this program, the categorical approach program.

While I think it is desirable to coordinate these programs with other programs, and provide a coordinated approach, I think the identity of this program and the specific nature of it is extremely important to maintain. Indeed, it must constitute, really, the strength and source of vigor of this program as it has developed in the past 5 years since it has been in operation.

I have had the privilege as one concerned with the inception of the program, and as a member of the council of the regional medical program, and I have had very close opportunity to work in the development of this program and to see it developed and, in actual reality, both in terms of its organizational development under the regional medical program council and also at the level of its operational activities. I can assure you that it has achieved a sense of vigor at the local level, both in terms of the cooperative efforts and cooperative arrangements and in terms of providing programs that are badly needed in advancing the care of heart disease, cancer, and stroke.

I am particularly pleased to see the addition of related programs, particularly the kidney disease program which, I think, adds a very important area of a related disease, which again constitutes a targeted approach to a very specific disease area. It is important in terms of advancing the methods by which we can control these programs and, particularly, for the relief of suffering by patients who have these diseases.

I have a statement which I would like to ask you to include in the record. I will not attempt to read this statement if you will provide me the opportunity of including it in the record.

Senator HUGHES. It will be included in the record in its entirety.

Dr. DEBAKEY. Another aspect that is important in this bill is related to the training program, training grants approach, to provide specific forms of training grant authority to meet specific needs. This particular aspect of the bill, I think, is extremely important, because in spite of the fact that we have authorization, legislation, and programs that meet manpower training needs, there are none that are specifically designed and specifically authorized to provide funds for these purposes.

I think it is extremely important as a part of the bill since in many ways it is this kind of training grant authority and these kinds of training programs that will help advance the methods by which we will control these diseases, and, indeed, bring to the people the knowledge that exists today to control many of these diseases. These include not only the training of professionals, both the long-term and short-term training, but also the training of our allied health personnel, technologists and people of that kind, who are badly needed to help carry out many aspects of the programs. So I think this aspect of the bill is extremely important.

There is one other area I would like to mention specifically. This is concerned with the authority for construction. It is true there exists, as I heard Dr. Egeberg point out a moment ago, other authorizations for construction in HEW. In fact, there are several other construction program authorizations that exist. But in the first place, the funds for all of these programs are in very short supply, making it almost impossible to meet the total construction needs for the various programs.

Secondly, the method by which the funding is made available, the mechanism by which the funding is made available to these various other programs to which reference has been made, are such that the regional medical program needs are simply not met within the priority of those mechanisms. It is for this reason that I think that aspect of the bill is an important one. It provides specific grant authority for the construction of specific facilities related primarily to this program and to no other program.

I think it is the only realistic mechanism by which construction authority can be obtained, by which, really, construction needs in this program will be met. I might say in my opinion these do not require large amounts of funds because these construction needs are fairly specific and are related to the needs within the regional medical program for fairly specific purposes where space is needed to carry out certain programs for training of both professional and nonprofessional personnel in relation to the training program referred to here for the training of technologists, for specific requirements in relation to certain kinds of care programs in certain institutions. These are, for the most part, for programs outside of the major medical centers. They would be in more peripheral areas, primarily, where construction needs cannot be met any other way.

I would also like to finally refer to a point I made earlier in relation to the specific targeted approach, the categorical approach, of

this program. I think it is extremely important to maintain its identity and its integrity, to maintain the mechanism by which it now operates since it is a program that has now achieved a certain identity with the profession, it has achieved the support and cooperation of virtually all elements of the profession, particularly in the various regions, and since is provides a targeted approach to major problems affecting the American people.

I do not think it would be wise to submerge this program in an overall type of health planning program. I think it is desirable to provide coordination, and this is being carried out to a certain extent now. But to remove this present mechanism and convert it to an entirely different type of overall umbrella system, I think, would tend to injure this program.

I want to thank you, Mr. Chairman, for the opportunity of being here today.

Incidentally, I have not had a chance to study or even read the administration bill. I am very much concerned about this. I would like to have the opportunity of reviewing this bill and submitting for the record my own views, and perhaps getting the opinion of the American Heart Association and the American Association of Medical Colleges.

Senator HUGHES. I am sure the committee would like to have your opinions, Dr. DeBakey, after you had a chance to review the legislation. We have not had the opportunity to become totally familiar with it.

(The prepared statement of Dr. DeBakey follows:)

PREPARED STATEMENT OF MICHAEL DEBAKEY, M.D., PROFESSOR OF SURGERY AND CHAIRMAN CORA AND WEBB MADING DEPARTMENT OF SURGERY, AND PRESIDENT BAYLOR COLLEGE OF MEDICINE, HOUSTON, TEXAS

Mr. Chairman and members of the committee, I am very happy to have the opportunity to speak in support of S-3355, the heart disease, stroke, cancer, and kidney disease amendments of 1970. I am also pleased to be testifying on behalf of the American Heart Association, and the Association of American Medical Colleges which fully supports this bill. This vital national program is at a very critical stage of development at the present time, and in my view, this bill will give the program important impetus. Fifty-five Regional Medical Programs have been developed on local initiative and now cover the entire United States. After varying periods of planning, the programs are entering the operation stage, carrying out specific projects of the improvement of health care services.

It is critical, therefore, that these programs be adequately funded to achieve the objectives toward which this planning effort has been directed. At the present time, there are $26.6 million in approved, but unfunded, grant requests, including the following projects:

A project in Houston, Texas, involves cooperative arrangements between a well-established major hospital and a new hospital in the ghetto area, Riverside General. Training of nurses for coronary care units will be provided for the new hospital in order to improve the quality of service in that hospital. Nurses from St. Joseph's Hospital will go to Riverside to help establish the new coronary care unit, one bed at a time. This project would have been an excellent instance of the extension of quality care to the underprivileged—a major health priority.

Another project in Texas seeking to improve health care for the economically deprived involved cooperative arrangements between Baylor Collge of Medicine, St. Elizabeth's Hospital, and eight major health and welfare agencies in Houston and Harris counties. The proposal was for Baylor to establish a rehabilitation evaluation unit at St. Elizabeth's Hospital, a hospital serving ghetto residents. The project was to have been under the direction of a Negro physician on the staff of St. Elizabeth's, with participation of physicians from the community.

A project in Missouri proposed to attack the problem of disability and death

from stroke and cardiovascular disease secondary to hypertension in a predominantly Negro area of Kansas City. In order to control high blood pressure in its early stages, medical assistants chosen from the "inner city" would be trained in case-finding and would be responsible for patient and public education. The project involved cooperation with the neighborhood health center of the Office for Economic Opportunity and the physicians in the community.

KIDNEY DISEASE

I fully endorse the inclusion of kidney diseases as one of the categorical diseases in this program. Actually, kidney disease has generally been covered as one of the so-called related diseases. However, the importance of kidney disease as a cause of death and disability more than justifies its specific mention and the earmark of funds. These earmarked funds will permit planning and operating projects for the better management of kidney disease to receive more adequate attention by Regional Medical Programs.

Mention of kidney diseases brings me to the subject of the categorical focus of Regional Medical Programs. There are those who recommend that mention of specific diseases should be removed from the Regional Medical Program legislation. I vigorously oppose this view and support the approach of S-3355. The categorical focus of Regional Medical Programs has been a great source of strength. Unquestionably, cooperative arrangements among providers of health care can and should ultimately have an impact on the totality of health care services, but the categorical focus gives specificity to the Regional Medical Programs which has been particularly valuable in the developmental phase. It may be that ultimately the categorical focus should be removed but, in my judgment, the approach of S-3355 is much more sound: broadening the categories and adding certain specific diseases. Once the program has been fully developed and a significant record of accomplishment in improving health care in specific diseases in the act has been achieved, then we can encourage the extension of these developments to the totality of health care services by removing the categorical focus.

SINGLE COUNCIL

It is my understanding that the Administration's proposal for the extension of Regional Medical Programs is to include that extension in a combined bill with the extension of comprehensive health planning and health services research and development. I can see no particular advantage to this proposal. Indeed, the submerging of a program like Regional Medical Program with clear-cut objectives and a very desirable and useful approach to those objectives in a bill that includes other elements does not seem judicious. One particular provision of the Administration's proposal impresses me as being very undesirable. The Administration proposes to establish a single advisory council for the three programs. I cannot see how a single council can deal constructively with the wide diversity of elements included in these three separate programs. Just as the categorical focus of Regional Medical Programs has been a source of strength, the council, considering in depth the many policy issues, has, I think, made a significant contribution to the success of the program to date.

TRAINING GRANTS

A major new provision of S-3355 is training grant authority that would allow the training of manpower to meet specific needs in the fight against heart disease, cancer, stroke, and kidney diseases.

The kinds of training for which this act would provide are best exemplified by the cancer control and neurologic disease control programs of the former division of chronic diseases. These programs have been directed to immediate needs for disease-specific training that are not satisfied by the established educational system.

For physicians and other professionals they provide intensive post-resident training in specific diseases to qualified specialists who except to make careers in clinical practice. The programs also provide short-term training in specific disease control procedures. Grants to selected centers of expertise enable them to teach specific concepts and skills to practicing professionals.

Grants under these programs have reinforced clinical disease teaching in the continuing educational programs of community hospitals, have enabled professional societies and the great cancer hospitals to present symposia and conferences, and have helped to integrate the contributions of many specialists.

These programs also develop and support specialized training for the technologists who must be available to back up physicians and scientists in many of our modern disease control procedures. The most dramatic examples of this function have been in the training of cytotechnologists and radiation therapy technologists.

In the control of chronic diseases, our knowledge often exceeds our capacity to apply it. This was true for years in the application of cytology to cancer detection. The Papanicolaou test for cancer of the uterine cervix has been known for years, but it was not widely applied until the Public Health Service training program enabled technologists to help physicians with the laboratory work. Today we have a similar situation in radiation therapy. New equipment and techniques are rapidly expanding this field. The number of patients who will benefit, however, will not increase as rapidly as it should unless we can train technologists to assist the physician specialists and multiply their effectiveness.

The objective in all of these kinds of training is to integrate specialized advanced concepts, skills, and procedures into the existing system of medical care. Training for this purpose has to be carried out in close conjunction with clinical practice. Its content must be in harmony with the professional concensus on clinical requirement.

None of these programs have been or can ever be massive movements. They are aimed at placing specific practical skills in the hands of existing working professionals.

The successful management and direction of these complex inter-regional programs will require expert knowledge in the specific disease under study. Large staffs and review committees should not, however, be necessary for each disease. Competence and experience already exist in the department, most notably at the National Institutes of Health. The Regional Medical Programs should use those unique resources and need not duplicate the effort. For example, large field studies in heart disease should be undertaken in concert with the National Heart and Lung Institute. All these mechanisms should be complementary, and should facilitate rapid application of new discoveries to all patients.

We in the medical profession have profound respect and very high regard for the professional and technical training systems of this country. We would not recommend that the Regional Medical Programs enter into any competition with that system, and we do not expect the proposed authority to generate such competition.

On the other hand, we believe that the Regional Medical Programs should be able to move, when necessary, to serve the clinical competence of the existing systems and to add new skills to those that are already in use. The Regional Medical Program has great potential for ascertaining the special needs of individual regions and for discovering the special capabilities of individuals centers of excellence. The proposed training authority will give the Regional Medical an enlarged capacity for accelerating the spread of new concepts and technology from the "have" regions to the "have not."

Senator Hughes. Would you elaborate a little more fully for the need for construction funds under the regional medical programs?

Dr. DeBakey. This is in relation to specific needs within the program. First, for example, in a hospital which is in a relatively small community, that is actually engaged in certain aspects of the regional program, for example, coronary care units, the need to provide for specific space for this type of unit in many of the smaller hospitals exist. They do not have this kind of space available. They would have to, in a sense, renovate and remove the activities within the space they have. But the addition of a small unit, perhaps costing in construction in the neighborhood of $150,000 to $200,000, would provide them with the kind of modern space they would need for this specific purpose. In other areas, they would need space, and I have seen this as I have visited some of the projects, for specific training activities. This is space which would provide the opportunity to train technologists, physicians practicing in that area, whenever they would be able to meet

and be trained in certain areas of cancer disease or heart disease control programs.

In the stroke program the same would exist. These are not large construction needs. Actually, they constitute relatively small construction needs. It is for this very reason in the priority of construction funding that exists now that there is little opportunity for them to get money from these other authorized construction programs in HEW.

For example, they simply would not be able to compete for research facilities construction programs. They would not usually be able to compete for the Hill-Burton programs. They would not be able to compete in any of these other programs for their specific needs. It is this kind of specific targeted need that I am referring to.

Senator HUGHES. Dr. DeBakey, we thank you very much for your testimony this morning, coming before the Congress to give us your thoughts. We also appreciate your opinions on the legislation. Thank you very much.

Dr. DEBAKEY. Thank you.

Senator HUGHES. The next witness will be Dr. Samuel L. Kountz, associate professor of surgery at the University of California, San Francisco.

Dr. Kountz, we welcome you this morning to the Subcommittee on Health. We appreciate your willingness to come forth and share your opinions and ideas with us.

You may proceed with your testimony as you desire.

STATEMENT OF DR. SAMUEL L. KOUNTZ, PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA, REPRESENTING NATIONAL KIDNEY DISEASE FOUNDATION

Dr. KOUNTZ. Thank you very much, Senator Hughes. I am delighted to be here. I cannot tell you how I am touched with the opportunity to appear before this committee.

I might say that I appear as a repesentative of the National Kidney Disease Foundation to discuss what I think is one of our great national problems. However, I would like to tell you a little bit about myself before I go into my statement.

I am emotionally touched to appear before this committee because this is the first time I have ever had the opportunity to appear before a committee of the national Congress. To come from rural Arkansas and to have an opportunity to study at three of our great institutions, certainly gives me profound confidence in the great ability of our country to address itself to many of our national problems.

My interests in kidney disease came about as a senior medical student at the University of Arkansas in 1958. It was in 1960 at Stanford University when I began my research into the problems of kidney transplantation. Since that time I have attributed more than 60 contributions to the literary on surgery and transplantation. For the past 2 years I have been at the University of California. Along with my associate, Dr. Belzar, we have developed the only reliable method of preserving the human kidney for more than 2 days, a step that is essential to the program I wish to discuss with you.

Today I would like to confine my remarks to this area, the area I have been working in for the past 10 years, namely, the treatment of

patients with end stage kidney disease by dialysis and transplantation.

A little more than a decade ago, kidney disease was 100 percent fatal. Today there is no need for that to be the case. I speak now specifically of the artificial kidney and kidney transplantation, which restores patients to a normal, productive life. Yet, nine out of every 10 patients with kidney disease are forced to die an elective death. This national crisis in medicine is unparalleled in our history, for never before has a proven lifesaving treatment been denied to so many primarily because of the lack of money. The recent advances in this field have made it frustrating for physicians to care for patients with chronic kidney disease, and I want to emphasize the word frustrating. Today physicians are forced to stand silently by and let their patients die when they know a proven form of treatment exists, which if it could be made available would save their lives. Most of these patients are young and in the most productive years of their lives. The loss to the country of their talents and skills is enormous and the suffering and loss to their families is incalculable.

The total number of patients with kidney disease that could benefit from dialysis and transplantation each year is small—8,000 to 10,000. The cost of treating this group of patients has been overestimated. When we began our transplant program at the University of California 6 years ago the average cost of the first 50 transplants was about $30,000 each. The cost of the next 100 transplants was reduced by about 50 percent, $15,000, and the cost of our last 50 transplants has been reduced even further, less than $10,000. I predict that a kidney transplant eventually will cost no more than other major surgical procedures.

Senators, it is exciting for me to be able to tell you about the impact a successful kidney transplant can have on a patient, his family and his community. For example, 6 years ago I cared for a young mother and schoolteacher who was dying of kidney disease. She was dramatically rehabilitated and restored to family and job by a transplant. For more than 5 years now she has been taking care of her family and teaching school. A young nurse in Palo Alto, Calif., dying of kidney disease was returned to her job several weeks after a successful transplant. A young physician-surgeon after a successful transplant was returned to his job as head of the department of surgery in his medical school. A businessman dying of kidney failure is now head of the housing authority for the city of San Jose, Calif., after a successful transplant. I have performed successful transplants in children, teenagers, and young adults and seen fear and anxiety turn into tranquility, a dream into reality, pain and suffering into a state of good health. I could go on and on and give almost 200 personal examples, but this is occurring not only in California, but in Texas, Minnesota, New York, Massachusetts, Pennsylvania, and many other areas throughout our great land. But, please remember these fortunate people represent only one out of every 10.

I wish to emphasize one other point and that is the prognosis for kidney transplant patients is excellent for many years and perhaps indefinitely. Indeed one of the most exciting recent findings is that patients surviving with transplants for 2 or more years rarely reject them. More than 95 percent of our transplant patients at the Univer-

sity of California, San Francisco, are completely rehabilitated and leading normal lives—some for more than 6 years.

I was tremendously struck by Senator Schweiker's remarks about his friend. This is a problem I have lived with for the past few years.

I would now like to speak specifically to the question as to why a system of delivery as envisioned in the regional medical programs is absolutely essential for delivering dialysis and transplantation as a service. The reason that a regional organization of dialysis-transplant services is mandatory revolves around the problem of how best to prevent the recipient of a kidney transplant from rejecting his graft, or selecting a patient that would most benefit from a kidney transplant. It is similar to typing for blood transfusions.

Recent advances using laboratory tests and a specifically programed computer have made it possible to select out of a pool of potential recipients that one patient who is the best match or in other words the least likely to reject his graft. To operate the system, however, requires that a large group of recipients, who are patients on the artificial kidney machine, must be available so that a good match can take place—and the larger the pool, the better the chances of a perfect match. This means that not only must the transplant center have access to every dialysis patient in the region, but in several adjoining regions. In fact recipient pools as large as 1,000 or more patients involving a region as large as the entire Western United States may be required, which projects the necessity of multiregional planning. At the present time we are organizing a cooperative program with the Pacific Northwest and I would like to introduce at this time a statement of my colleague and friend, Dr. Belding Scribner, of Washington, which documents the necessity of cooperative regional planning for kidney disease control.

The Chairman. That will be accepted for the record.

(A paper by Dr. Belding Scribner follows:)

A Regional Approach to the Control of Kidney Disease by Belding H. Scribner, Professor of Medicine and Head Division of Kidney Diseases, University of Washington, Seattle

The Nation today is facing a mounting crisis in the delivery of health care. At the same time in the control of kidney disease a problem has developed that is unique in the history of medicine: an estimated 9 out of 10 patients with chronic renal failure who could be restored to normal health are being allowed to die because existing health care programs simply do not have the funds to provide proven lifesaving treatments using transplantation of kidneys or the artificial kidney. It is my strong conviction that by regionalizing kidney disease control as envisioned in Senate Bill #3355 this unique problem will be solved in a much shorter time with great savings in money and health manpower and the programs developed will provide important new guidelines to the solution of many other health problems.

In my region, Washington, Idaho, Western Montana and Alaska we have been grappling with the problem of kidney disease control longer than has any other region and as a result we presently have the highest per-capita number of kidney patients whose lives depend on a renal transplant they have received or on an artificial kidney which they operate in their own home. This experience began 10 years ago when our first 3 patients, the first of their kind in the world, began treatment with the artificial kidney. It is of interest that today all 3 continue to be healthy productive individuals.

This extensive experience with renal transplantation and the use of the artificial kidney convinced me back in 1966 when regional medical programs were being introduced that the problems to be faced in kidney disease control were so ideally suited to a regional as opposed to a local, or state-wide approach

that I wrote a letter explaining my position to Dr. Robert Marsten who at that time was head of R.M.P. This letter was subsequently included as an appendix to the report of the Gottshalk Committee which also recommended a regional approach.

My convictions are even stronger today that kidney disease control should be regionalized for the following three reasons:

1. With the introduction of these new life-saving treatments there has been an enormous increase in activities in the field of kidney disease. The annual expenditure for renal transplants and hemodialysis (artificial kidney treatments) in the State of Washington (pop. 3 million) which was non-existent 5 years ago now is 1.5 million dollars per year and increasing by .5 million per year. This large increase in activity in the field of kidney disease has intensified greatly the need for physicians in our area who are knowledgeable in kidney disease and its control. For example, the city of Tacoma, Washington, a community of 300,000 people, had no physician trained in kidney disease control until July of 1969.

The best way to rapidly increase physician knowledge of kidney disease is to organize a carefully planned coordinated program of physician education that avoids duplication on the one hand and effectively reaches all interested physicians on the other. Obviously a coordination of educational efforts on a regional basis is the easiest and most efficient method.

Physician education is most effective if it can be tied into ongoing communication about specific patients. A unique and ideal opportunity to use this method exists because all dialysis patients in the region are on home dialysis or have had a transplant and the majority are cared for by their local physician. Hence, there is of necessity a continuing dialog between the transplant center at the University, the artificial kidney centers in the region, and physicians throughout the region who care for these patients. It has become apparent that most of these physicians have become eager to learn more about kidney disease.

2. There is an urgent need to organize an ongoing program of renal disease detection so that appropriate diagnostic and therapeutic measures can delay or even prevent the need for dialysis and transplantation. Of greatest importance here is earlier and better use of urologic methods to detect and correct defects in children. Early detection of unsuspected chronic parenchymal disease will permit earlier control of hypertension which can prolong useful function for several years. These detection programs to be carried out efficiently are best organized on a regional basis.

3. Finally, experience in this region clearly indicates that the administration and operation of a dialysis-transplant program demands a regional approach for the following reasons:

(a) A home dialysis training unit to operate efficiently must train at least 12 patients per year which requires a population base of at least half a million people.

(b) Lines of communication between the training center and the local physician and his home dialysis patients must be established because the local physician cannot provide technical backup for the operation of the artificial kidney which must be provided by the center.

(c) The entire operation of a transplant program must be organized regionally because in order to operate properly it must transplant at least 50 patients per year which requires a population base of at least 2 million. Certain specific requirements of a transplant program demand a regional approach:

(1) Successful matching of a given cadaveric kidney requires that the largest possible number of dialysis patients be pre-types and this typing information be available for instant comparison at the transplant center. Furthermore, methods of instant communication have to be established between the transplant center and all dialysis patients in the region so that each can be called when his kidney becomes available. Actually it now is becoming apparent that multi-regional cooperation will be necessary in order to establish large enough recipient pools of patients on dialysis to be able to effect good matches for even the majority of cadaveric kidneys that become available. A pool as large as 1,000 dialysis patients may be required which would involve a region as large as the entire Western United States.

(d) In order to successfully harvest sufficient cadaveric organs a carefully organized and coordinated program or organ retrieval and preservation must be established which involves cooperative efforts among all the major medical centers in the region.

In summary, it is increasingly apparent from accumulating experience in our area that kidney disease control is uniquely suited to a regional approach and that in finding solutions to the problems to be faced can establish important new guidelines for improving delivery of health care in general. For example the fact that in 5 years we have been able to move the artificial kidney from the operating room of the hospital to the bedroom in the home of the patient as demonstrated all sorts of new ideas particularly in the area of increasing the use of home care for the treatment of chronic illness thereby decreasing hospital and nursing home utilization.

Finally a word about cost projections. There has been widespread misunderstanding about the ultimate cost to the federal government of the program for kidney disease control; a case in point being the one billion dollar seven year projection of the Gottschalk report. At this time 100% of the cost of dialysis treatment now is being borne locally by a combination of insurance, fund drives, other patient funds and appropriations from State legislators and some funds from federal vocational rehabilitation. Funding for other kidney disease control come from other normal sources of revenue. The future role of the Federal Government as carried out through the new regional medical programs will be to catalyze the establishment of the regional organization and fund on a temporary basis certain key components particularly in the field of renal transplantation. It is important to understand that in the 60's artificial kidney treatment was carried from the research stage through the demonstration stage largely by federal grants, most of which now have been phased out. Kidney transplantation is just now ready to be moved to the demonstration stage which should require 5–10 years to complete and should very properly be funded on a temporary and declining support basis by the program envisioned in this important legislation.

Dr. KOUNTZ. Mr. Chairman, at this point I would like to describe for you just how our dialysis-transplant program actually operates on a regional basis. A young New York executive while vacationing in San Jose, Calif., was involved in a tragic and fatal accident. At the time of his death a card was found on his person, which stated that he wished upon his death to have his organs made immediately available for transplantation. Our surgical team was notified of this fact and his kidneys were placed on our kidney preservation machine, which I referred to earlier. While the kidneys were being preserved in perfect condition on the machine, a tissue-typing was being performed in the laboratory as a basis for selecting the dialysis patient in our region most suitable to receive the donation. The results of these tests were then fed into the computer which contained the information for all dialysis patients in our region. In this case the computer told us that there were no matches in our region which meant that we might have to discard these valuable organs. We then turned to a computer in Los Angeles where the tissue-types of a larger pool of recipients were stored. The computer came up with four patients, one in Cleveland, Ohio, one in Denver, Colo., one in Phoenix, Ariz., and one in Los Angeles, Calif. The one from Los Angeles was selected because he was the only one of the four who could afford the air fare. In 2 weeks he was returned home to his family and in 6 weeks he was back on his job as an engineer.

The exciting sequence of events that I have just described for you could only happen in the San Francisco region at this point in time since our techniques of kidney preservation and matching to find the best dialysis patient are recent developments of our research program. However, now that the system is working it becomes applicable all across the Nation which means that many other areas must now hasten to set up their regional kidney transplant programs. The only way this can happen in a reasonable length of time is by adding kidney disease to the title of the regional medical program, authorizing

the modest sum of $15 million for the first year and give kidney disease appropriate representation in the national council of the regional medical program.

Finally, Mr. Chairman, I would like to briefly summarize the problem:

(1) Kidney disease kills 8,000 to 10,000 of our most productive citizens each year.

(2) Proven forms of treatment, dialysis, and transplantation, can save their lives, but because of lack of funding a proper regional approach is now being made available to only one out of every 10. Hence 9,000 are dying needlessly who could be saved.

(3) I strongly urge this committee to enact S. 3355, which I believe will facilitate activation of these living savings programs at the lowest possible cost to the Government and with the most efficient use of medical manpower. Such a program could serve as a model to show how economies could be effected in many other areas of health care delivery.

I very much appreciate the opportunity of appearing before this committee.

The CHAIRMAN. Thank you, Dr. Kountz.

As you presented your statment, I was wondering when all of this marvelous kidney treatment came about and I remembered that it has been within the past 10 years.

Just before I came here, when I was a practicing attorney, one of the last cases I had involved a young girl about 12 or 13 who had her kidneys irreversibly damaged in an automobile accident. She died a very painful and horrible death. There were no dialysis patients then. There was no treatment for uremic poisoning.

I have known of other cases in my life where poisoning became irreversible and they died very painful and tragic deaths. I know of another accident where a driver whom I knew went off a bridge, about 14 years ago, near Austin. He had similar kidney injuries and he died.

This progress that has been made is remarkable, and I congratulate you on your great contribution.

Are you a native of Arkansas?

Dr. KOUNTZ. Yes, I am.

The CHAIRMAN. As a result of this growing and expanding technique do you foresee relief from kidney disease and injuries? Do you foresee the need for construction funds for kidney centers? Is there any need for new funds for new construction, to have these centers around the country that you have described?

Dr. KOUNTZ. I think there is, Senator Yarborough. I completely agree with the statement of Dr. DeBakey. Hospital centers were not designed for dialysis and transplantation. At our institution we scheduled a transplant operation involving a live donor. In order to do such an operation, we need two operating rooms. They only offered us one room. This does not exist in the ordinary hospital. So I think there will be a need for the construction of new facilities.

The CHAIRMAN. You wouldn't agree with Dr. Egeberg's statement that they oppose the provisions which would authorize new construction of demonstration, research, and training facilities?

Dr. KOUNTZ. I would like to have the opportunity before answering that to study Dr. Egeberg's statement and that bill before I answer.

The CHAIRMAN. He said we don't need any more construction. Of course, this bill includes not only heart disease, cancer, and stroke, but also kidney disease.

Thank you for your fine contribution.

Senator Hughes?

Senator HUGHES. Dr. Kountz, I think, like Dr. DeBakey, it might be helpful to the chairman and the subcommittee if you would go over this bill and send us your opinions of it.

Dr. KOUNTZ. I would be delighted to do so.

Senator HUGHES. You haven't had the opportunity at this point to do that.

These are rather exciting things you have been saying.

How long can you preserve the kidney?

Dr. KOUNTZ. We have preserved a kidney for 50 hours. In the laboratory we have gone to 4 days. We think 50 hours is enough time to transport a patient from many places throughout this great country with our magnificent air transportation. We have transplanted patients after having kidneys on our preservation unit from as far away as Phoenix, Ariz.

Senator HUGHES. Is it expensive to preserve the organ?

Dr. KOUNTZ. Not expensive at all, once you have the techniques developed. I think this is something grossly overrated. I transplanted a patient several weeks ago and he came back after discharge from the hospital and brought his hospital bill. It was $3,600 for the entire transplant. He had saved up $20,000, thinking that would be the cost.

I would predict that this operation will cost no more than any other major surgery.

Senator HUGHES. Do you think it is possible to extend this time?

Dr. KOUNTZ. Yes, it is, but we don't feel at the moment that it is really necessary. With research we will be able to preserve a kidney for several days. But at the present time, from a scientific point of view, 2 days is really all the time that you need.

Senator HUGHES. Do you have any capability of transporting a preserved kidney?

Dr. KOUNTZ. Yes, we do.

Senator HUGHES. That is, from one area of the country to another, rather than transporting the patient.

Dr. KOUNTZ. We have transplanted a kidney shipped to us from Salt Lake City. We have transplanted a kidney transported to us from Los Angeles. We have shipped kidneys from San Francisco to Los Angeles because we didn't have a patient that matched the kidney.

I would like to emphasize that the medical program is designed for the problems unique to the kidney. For this program to succeed scientifically it must be done on a regional basis. It can't be done any other way.

Senator HUGHES. How many preservation units are there in the country?

Dr. KOUNTZ. I can't answer that. I think this is a recent development in our own research program. We are just now making our scientific findings available to the medical profession. I don't think there are too many available, but it would not take too long to develop.

Senator HUGHES. Does this require specialized procedure and training for a surgeon to handle this type of transplant?

Dr. KOUNTZ. Well, it does take training, and we do need more trained personnel. But I don't think we are lacking in talent in that area. We just need the funds to provide the opportunity to train them.

Senator HUGHES. Thank you very much, Dr. Kountz.

I might ask you one final question: Do you think it is possible, perhaps, with the procedures now underway in kidney transplants, to extend this to other organs of the body?

Dr. KOUNTZ. We certainly have that in mind. I think this will require a little more work at the scientific level, the research level. It is certainly not ready to be delivered and is not as advanced as with the kidney. But I do think in the future we will be doing transplants with other organs.

Senator HUGHES. Thank you.

The CHAIRMAN. Dr. Kountz, I believe your testimony states that a person with the dialysis machine uses three treatments a week, with 10 hours required on each occasion. How many patients do we have in the United States today, if you know, without kidneys or with kidneys not functioning where they must have the dialysis machine and must use it?

Dr. KOUNTZ. We estimate there are about 10,000.

The CHAIRMAN. How many dialysis machines are there?

Dr. KOUNTZ. I think there are about 3,000 patients at the present time who are on dialysis.

The CHAIRMAN. Some doctors have to make a choice as to who goes on dialysis and, therefore, decides who lives and who dies?

Dr. KOUNTZ. That is correct. It is a painful experience.

The CHAIRMAN. I notice another fact in your statement, that most of these people are young or in the prime of life who have this kidney trouble.

Dr. KOUNTZ. That is correct.

The CHAIRMAN. It is not a disease of aging?

Dr. KOUNTZ. That is correct. I have a young man who wants to become a Senator.

The CHAIRMAN. If there are no further questions, we thank you very much, Dr. Kountz, for your contribution.

Dr. DeBakey, I read your statement, what you said about merging these regional centers with just one advisory board for all of these programs, and what is to be accomplished in the future under the regional medical programs.

Thank you very much. That shows your great scientific expertise and your ability to respond that soon.

(The prepared statement of Dr. Kountz follows:)

PREPARED STATEMENT OF SAMUEL L. KOUNTZ, ASSOCIATE PROFESSOR OF SURGERY AT THE UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CALIF.

Mr. Chairman and members of the committee, I am Samuel L. Kountz. Associate Professor of Surgery at the University of California, San Francisco, California. I am very grateful for this opportunity to appear as a representative of the National Kidney Foundation in support of S. 3355 to extend Regional Medical Programs to include Kidney Disease. I will address myself to the area in which I have been working for the past ten years, namely the treatment of irreversible kidney disease by dialysis and transplantation. I understand my

colleague and friend, Dr. George E. Schreiner, will appear before you tomorrow, February 18, 1970, to discuss some of the broader aspects of kidney disease in terms of early diagnosis, other forms of treatment and prevention.

I became interested in the problems of kidney disease as a senior medical student at the University of Arkansas School of Medicine, Little Rock, Arkansas in 1958. My research in this field began in 1960 during my residency in surgery at Stanford University School of Medicine, Palo Alto, California. It was during this period that I became associated with Professor Roy Cohn at Stanford who performed the first successful kidney transplant in California in 1960. Since that time I have authored more than 60 contributions to the scientific literature in surgery and transplantation. I am an active member of the national and international societies in nephrology and transplantation. For the past two years I have been associated with Dr. Folkert O. Belzer at the University of California, San Francisco, where we have developed the only reliable method of preserving a human kidney for more than two days, a step which is essential to large scale cadaveric transplantation. I have been involved in the care of almost 300 patients receiving kidney transplants, both from related donors and cadavers.

Mr. Chairman, little more than a decade ago chronic kidney disease was 100 per cent fatal. Now, as a result of research, this is no longer true. I speak specifically of the artificial kidney machine and the kidney transplantation, which restores patients to a normal productive life. Yet, nine out of every ten patients with kidney disease today are forced to die an elective death. This national crisis in medicine is unparalleled in our history, for never before has a proven lifesaving treatment been denied to so many primarily because of the lack of money. The recent advances in this field have made it frustrating for physicians to care for patients with chronic kidney disease, and I want to emphasize the word *frustrating*. Today physicians are forced to stand silently by and let their patients die when they know a proven form of treatment exists, which if it could be made available would save their lives. Most of these patients are young and in the most productive years of their lives. The loss to the country of their talents and skills is enormous and the suffering and loss to their families is incalculable.

The total number of patients with kidney disease that could benefit from dialysis and transplantation each year is small—eight to ten thousand. The cost of treating this group of patients has been overestimated. When we began our transplant program at the University of California six years ago the average cost of the first 50 transplants was about $30,000 each. The cost of the next 100 transplants was reduced by about 50 per cent ($15,000) and the cost of our last 50 transplants has been reduced even further (less than $10,000). I predict that a kidney transplant eventually will cost no more than other major surgical procedures.

Senators, it is exciting for me to be able to tell you about the impact a successful kidney transplant can have on a patient, his family and his community. For example, six years ago I cared for a young mother and school teacher who was dying of kidney disease. She was dramatically rehabilitated and restored to family and job by a transplant. For more than five years now she has been taking care of her family and teaching school. A young nurse in Palo Alto, California dying of kidney disease was returned to her job several weeks after a successful transplant. A young physician-surgeon after a successful transplant was returned to his job as head of the Department of Surgery in his medical school. A businessman dying of kidney failure is now head of the housing authority for the city of San Jose, California after a successful transplant. I have performed successful transplants in children, teenagers and young adults and seen fear and anxiety turn into tranquility, a dream into reality, pain and suffering into a state of good health. I could go on and on and give almost 200 personal examples, but this is occurring not only in California, but in Texas, Minnesota, New York, Massachusetts, Pennsylvania and many other areas throughout our great land. But, please remember these fortunate people represent only one out of every ten who could be saved! I wish to emphasize one other point and that is—the prognosis for kidney transplant patients is excellent for many years and perhaps indefinitely. Indeed one of the most exciting recent findings is that patients surviving with transplants for two or more years rarely reject them. More than 95 per cent of our transplant patients at the University of California, San Francisco, are completely rehabilitated and leading normal lives—some for more than six years.

I would now like to speak specifically to the question as of why a system of delivery as envisioned in the Regional Medical Programs is absolutely essential for delivering dialysis and transplantation as a service. The reason that a regional organization of dialysis-transplant services is mandatory revolves around the problem of how best to prevent the recipient of a kidney transplant from rejecting his graft. Recent advances using laboratory tests and a specially programmed computer have made it possible to select out from a pool of potential recipients that one patient who is the best match or in other words the least likely to reject his graft. To operate the system, however, requires that a large group of recipients, who are patients on the artificial kidney machine, must be available so that a good match can take place—and the larger the pool, the better the chances of a perfect match. This means that not only must the transplant center have access to every dialysis patient in the region, but in several adjoining regions. In fact recipient pools as large as 1000 or more patients involving a region as large as the entire western United States may be required, which projects the necessity of multi-regional planning. At the present time we are organizing a cooperative program with the Pacific Northwest and I would like to introduce at this time a statement of my colleague and friend, Dr. Belding Scribner of Washington, which documents the necessity of cooperative regional planning for kidney disease control.

Mr. Chairman, at this point I would like to describe for you just how our dialysis-transplant program actually operates on a regional basis. A year ago, a young New York executive while vacationing in San Jose, California, was involved in a tragic and fatal car accident. At the time of his death a card was found on his person, which stated that he wished upon his death to have his organs made immediately available for transplantation. Our surgical team was notified of this fact and his kidneys were placed on our kidney preservation machine, which I referred to earlier. While the kidneys were being preserved in perfect condition on the machine, tissue, typing was being performed in the laboratory as a basis for selecting the dialysis patient in our region most suitable to receive the donation. The results of these tests were then fed into the computer which contained the information for all dialysis patients in our region. In this case the computer told us that there were no matches in our region which meant that we might have to discard these valuable organs. We then turned to a computer in Los Angeles where the tissue-types of a larger pool of recipients were stored. The computer came up with four patients, one in Cleveland, Ohio, one in Denver, Colorado, one in Phoenix, Arizona and one in Los Angeles, California. The one from Los Angeles was selected because he was the only one of the four who could afford the air fare. In two weeks he was returned home to his family and in six weeks he was back on the job as an engineer.

The exciting sequence of events that I have just described for you could only happen in the San Francisco region at this point in time since our techniques of kidney preservation and matching to find the best dialysis patient are recent developments of our research program. However, now that the system is working it becomes applicable all across the nation which means that many other areas must now hasten to set up their regional kidney transplant programs. The only way this can happen in a reasonable length of time is by adding Kidney Disease to the title of the Regional Medical Program, authorizing the modest sum of $15 million for the first year and give kidney disease appropriate representation in the national council of the Regional Medical Program.

Finally, Mr. Chairman, I would like to briefly summarize the problem:

(1) Kidney disease kills eight to ten thousand of our most productive citizens each year.

(2) Proven forms of treatment, dialysis and transplantation, can save their lives, but because of lack of funding for a proper regional approach, they are now being made available to only one out of every ten patients who could be saved. Hence, 9,000 productive young Americans continue to die needlessly each year.

(3) I strongly urge this Committee to enact S. 3355, which I believe will facilitate activation of these living savings programs at the lowest possible cost to the government and with the most efficient use of medical manpower. Such a program could serve as a model to show how economies could be effected in many other areas of health care delivery.

The Chairman. At this point we will receive the statement of Senator Kennedy of Massachusetts.

(The statement of Senator Kennedy follows:)

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

I am pleased to be able to participate in the deliberations of the subcommittee on the operation of the regional medical program. I am also pleased to be a cosponsor of S. 3355, the major bill introduced by Senator Yarborough to extend and improve the program and the principal focus of these 2 days of hearings.

The original regional medical program was inaugurated in 1965 with the enactment of the heart disease, cancer, and stroke amendments to the Public Health Service Act. The goal of the program was to use research, continuing education, and training to achieve a major breakthrough in the care of patients suffering from these and related diseases. In particular, we hoped that the program would pioneer in new methods for the exchange of information among those involved in the delivery of health care in medical schools, medical centers, community hospitals, and other health institutions and organizations.

Today, RMP is at last moving into high gear. Fifty-five regional medical programs covering the entire Nation have been established, and an unprecedented number of participating physicians, medical schools, medical centers, hospitals, State and city agencies, and voluntary organizations have become involved. I believe that the program represents one of the most fertile approaches we have yet taken to enlist the energies of all elements of the health community in our efforts to improve the organization and delivery of health care.

One of the most significant signs of the increasing vitality of RMP was its ability to weather the crisis in health appropriations last year and persuade the Senate to raise the $76 million in funds appropriated by the House to the full $100 million requested by the administration for fiscal year 1970. In previous years, as members of the subcommittee are well aware, appropriations had been somewhat greater than actual expenditures, because administrators understood that the program was in its infant stage. As a result, only the most innovative proposals were funded.

Today, thanks in large part to the success of RMP, we now have far more doctors and health organizations working together cooperatively then anyone might have expected a few years ago. I believe that we must continue to our efforts to expand the program and increase its funding. We simply cannot afford to disillusion the people who have done so much and worked so hard for the success of the program. In particular, we must insure that the program is sufficiently well funded to preserve and expand the "core staffs" already assembled in the 55 regions.

In particular, I hope that in these hearings we can look closely into the question whether the program should flatten out after 1972, at the funding level of $250 million as proposed in S. 3355. At the inception of the program, we estimated that the ideal expenditure for the program would level off at about $2 or $2.50 per capita, or a total annual level of about $400–$500 million.

In the course of these hearings, I hope that we will be able to determine whether the original projection is still valid. We know, for example, that there are a significant number of RMP projects that have been approved by the National Advisory Council, but which have not yet been funded because the appropriations have been to low. Indeed, according to the best available estimates, the amount of approved but

unfunded projects now totals $30 million. In its report last December, the Senate Appropriations Committee cited one such project of particular importance—an imaginative projects designed to encourage high school students to pursue health careers.

In addition, ongoing programs are also being starved for funds. I understand that about 11 of the most recently funded programs are still restricted to planning, and are unable to move into full operation because of the lack of resources. In other cases, RMPs are being funded at the same level as in prior fiscal years, even though they are ready and able to expand. In fact, these programs are not even being asked to stand still. Because of inflation, they are being asked to take a step backward.

Because of its involvement with the medical schools and the universities, and because of the cooperation and communication it has generated, I believe that RMP holds great promise for influencing the health delivery system in a beneficial way. Further, because it has encouraged the programs to develop as conceived by the indigenous medical forces in a State, or a metropolitan area, it holds equally high promise for successfully regionalizing the health care system after years of relatively unproductive efforts toward this purpose.

In my own region, the tristate regional medical program is developing the advantages of its three-State area by sharing resources. Although many of the resources are concentrated in Boston, a major project to train nurses in coronary care is based at the Mary Hitchcock Hospital in Hanover, N.H., and has enrolled trainees from hospitals in northern Massachusetts as well as from New Hampshire.

Another tri-State project is a cooperative program of the schools of medicine at Harvard, Tufts, and Boston University to establish a comprehensive cardiovascular program at Boston City Hospital. This project is developing the joint operation of a cardiovascular service which will train residents, practitioners, and paramedical personnel. Through this project, the program is making a major contribution to a better system of caring for the inner city population, especially its low-income groups.

Also, a cancer project has been initiated involving the Boston University Medical Center and seven other community, Federal, and municipal hospitals. Its objective is to make optimal therapy available to cancer patients. It involves the creation of a model cancer unit at the center for demonstration, training, and the rapid application of the latest research advances.

Another project of the tristate RMP, I understand, is the efficient coordination of the regional medical program and comprehensive health planning. The goal of the project, which seems to be working well in our region, is to avoid overlap and to develop an efficient health care system which makes maximum use of the region's extensive but necessarily finite resources. Correcting the existing fragmentation of services is a crucial objective.

It is our responsibility to insure that we preserve the momentum of this promising and innovative Federal program in all parts of the Nation. I commend the distinguished chairman of the committee, Senator Yarborough, for his leadership in this area, and I look forward to these hearings as a major step forward toward our goal.

Earlier this week, I received a detailed letter on the tristate program from Mr. Robert P. Lawton, its deputy director, and I ask the chairman's consent that the letter may be printed in the record of these hearings.

In closing, let me say that last fall, in the course of the controversy over the funding of the regional medical program for the current fiscal year, a number of letters came to my attention describing the importance of the program and the drastic impact of the proposed budget cuts. Because of the importance of the issue, I also ask the chairman's consent that excerpts from these letters may be printed in the record of these hearings.

TRI-STATE REGIONAL MEDICAL PROGRAMS OF MASSACHUSETTS,
NEW HAMPSHIRE, AND RHODE ISLAND.

HON EDWARD M. KENNEDY,
U.S. Senate,
Washington, D.C.

DEAR SENATOR KENNEDY: I am in strong support of S. 3355 to extend and expand the Regional Medical Program, since it calls for effective continuation of a vital instrument for improving American health care. It broadens the scope of regional medical programs in terms of categories of disease, it includes contracts for training and clinical field trials, and in other ways it recognizes that the efforts to regionalize health care beneficially must be carried forward on a broad front.

In a rapidly growing number of the 55 regions, the Regional Medical Program is demonstrating its effectiveness in generating change, and in controlling change, so that the American Health Care System grows, both in the quality and in the equality with which it serves all the people and the effectiveness with which it uses its resources. Consequently, we should nurture its success, broaden its scope, and increase its momentum.

However, how can we lay on the Regional Medical Program this properly broadened charge and then not authorize, appropriate and release the funds for implementation is both incomprehensible and dangerous.

Current expenditures from all sources, public and private, for health in the U.S. are about $60 billion per year. It is estimated that this total national expenditure for health will grow to $100 billion in 1975. Of the current level of $60 billion, a little over $13 billion represents the health expenditures of the federal government. Of this $13 billion, which is largely spent on Medicare and Medicaid, only about 200 million federal dollars per annum are expended through RMP and parts of Comprehensive Health Planning, maternity and youth programs and the like which generate improvement in the *system of delivering health service.*

Under Title 19 (Medicaid) alone, federal and state expenditures in fiscal 1969 were approximately $5 billion for the purchase of health services. It is estimated that these $5 billion will grow to $24 billion in 1975. What we have is rapidly escalating investment, if that is the right word, in the purchase of health services, and a miniscule increase in our investment in the ability of the health systems to supply those services. If we do not slow the growth of purchasing power for health services, or rapidly increase the investment to improve the quantity and quality of those services, or some combination of the two, it is quite likely that the continuing overbalance in the peoples' ability to pay for services will result, not in an improvement in health care, but in a worsening in health care. At the present time, the system is strained to an extreme and a continuation of this trend could be disastrous. The present health delivery system could fall apart under the strain of increased purchasing power, would take years to be reconstructed, and might never regain the quality of individual health service now provided by the private sector.

In terms of S. 3355, I recommend that the level of support for grants be increased by $50 million over the recommendation in Section 3 for each of the next three fiscal years, to help Regional Medical Programs assist in meeting this demand. It would be entirely reasonable to pull this increase from Title 19 Appropriations.

Although not technically the business of this legislation, I cannot refrain from a statement about the shockingly low budget for regional medical programs for

Fiscal 1970 and 1971. $93.5 million and $99.5 million, including carryovers, in the respective years for RMP grants is incredibly inconsistent with the success and importance of regional medical programs, which is implicit in the legislation before you. Appropriations should be at the full level of authorization. What saddens and puzzles me even more is the withholding of $20 million from the expected 1970 appropriations. This practice is another manifestation of our skewed national priority, and I pray that it will not be exercised.

I think the most exciting development in Regional Medical Programs is their growing role in the *process* of the health service planning and in the solving of health service system problems. Demonstrations of new ways of applying medical knowledge and of improving health service are important. But even more fundamental is the establishment of a mechanism and process to solve health service problems, which will continue to arise from new knowledge and social change. More and more, the private and public sectors of health are turning to the regional medical programs for the solving of problems and for help in the management of change. I see regional medical programs, over the long haul, as the box into which health service problems are dropped and which will not only provide the answers but also stimulate implementation of those answers. For this vital service, I suggest that an eventual annual investment of $2 per capita would be a bargain.

Lastly, I hope that the spirit and letter of this legislation will increase reliance on the individual regions to develop their own programs and to manage their grant funds. Under consideration in Regional Medical Programs is a system under which the more established regions will have their total program, and consequently their *process* for improving health service delivery, examined and reapproved at stipulated intervals. Under specific controls, such regions would have the right to manage a portion of their grant funds between anniversaries under the approval of their regional Advisory Group and under priorities expecially appropriate to that region and established by the Regional Advisory Group. Such a system would allow a region which had demonstrated a high type of organization and responsibility to respond more quickly to regional needs and problems.

After several decades of relatively fruitless effort toward regionalization, Regional Medical Programs are proving to be the best bet for reorganizing the method, on a regional basis, of caring for patients with major diseases. They deserve continued major encouragement and support.

Cordially yours,

ROBERT P. LAWTON, *Deputy Director.*

EXCERPTS FROM LETTERS ON THE BUDGET CRISIS IN THE REGIONAL MEDICAL PROGRAM

ALABAMA

In Alabama, Dr. Benjamin B. Wells, Program Coordinator of the Alabama Regional Medical Program reports:

"The reduction of funds that would follow from the projected cuts in the Federal budget will emasculate the Regional Medical Program in Alabama.

"In pursuit of our original charge, we have mounted an all-out *effort* to secure the interest, support and active involvement of health care institutions, groups, individuals and the general public throughout this state. We have carefully avoided giving the notion that we were or should be a major source of funds for the improvement of health services, but we have encouraged a large number of cooperative ventures through the use of our core staff and the establishment of linkages to the University Medical Center in Birmingham. Unless we can press forward at this time, the momentum of two years will be quickly lost.

"Many similar efforts are at the most critical point in their evolution. Our failure to progress at this time may result in years of delay before similar multilateral commitments can be reformulated."

ARIZONA

The Arizona Regional Medical Program, coordinated by Dr. D. W. Melick, will be in severe difficulty:

"For the past two years we have been in the planning phase of our operation. The planning, in order to bring forth the best in grant applications, has been a tedious and time-consuming process.

"We are now looking forward to a shift from planning to operational status. We have had approval of the National Advisory Council for certain of our project applications. We are awaiting funding. If this is forthcoming we expect to go into the operational phase January 1, 1970.

"Failure to fund our program will undermine all of our efforts in careful and meticulous planning. Of more importance, it will disrupt the enthusiasm we have engendered. It will result in a good deal of frustration for the citizens of our State who have assisted us in getting our plans in presentable form. It will delay us from presenting to our citizens, visible evidence of action. Action is certainly necessary to pacify those individuals who may criticize us for a prolonged period of planning."

COLORADO, WYOMING

Dr. Howard W. Doan, who directs the Colorado-Wyoming Regional Medical Program, has also indicated the difficulties of low funding of RMP's occurs:

"At the present time we have nine operational projects. Most of them indicate a healthy growth anticipated for the next two years as a result of increased interest on the part of health professionals in the region and a growing awareness of the potential of the Program.

"In addition, we have six or seven developing projects, five of which are now under review by the National Advisory Council. If our funding is held at the present level, it will be difficult to implement any of these without placing current projects in jeopardy. We have, for example, a comprehensive project in heart disease which has been developed in collaboration with the Colorado and Wyoming Heart Associations. This project will be funded at a most austere level if our budget requests are not honored. I doubt the wisdom of beginning any major project if it cannot be operated properly. We have another project under review which is broad and covers almost the entire field of cancer in children. This project is one of the finest I have ever seen, and our failure to subsidize it will be a shame."

DELAWARE VALLEY

In New England's Greater Delaware Valley Regional Medical Program, Dr. George R. Clammer, its Executive Director, reports:

"We would anticipate that the major effect of the reduction will be to significantly curtail funding of new operational projects. This would occur at a time when we expect the growing involvement within our Region to result in more requests for operational projects. In addition, we already have several approved projects which have not been funded as yet and which may not get off the ground.

"It is likely that these effects will detract significantly from the interest in and enthusiasm for RMP which has developed in our Region as a result of extensive efforts during the past two years."

DISTRICT OF COLUMBIA

Here in Washington, D.C., the Metropolitan Washington Regional Medical Program will be prevented from attaining its potential. Dr. Arthur E. Wentz, Program Coordinator reports:

"With almost one and one-half million dollars of unfunded approved proposals for this small Region it is becoming increasingly difficult for the Planning and Program Committee to engender continued interest, much less enthusiasm, in the presentation of additional proposals to afford a comprehensive program defined in the objectives of the law. This is a Region which has capability of presenting such proposals but those sources are no longer willing to sponsor the cost in manpower and dollars to structure these proposals when those approved by the Council go unfunded."

HAWAII, AMERICAN SAMOA, GUAM, MICRONESIA

In Hawaii, Dr. Masato Hasegawa, who coordinates the Program for that state as well as American Samoa, Guam, and Micronesia, states:

"As you know, like other regions throughout the Nation, we have been slowly developing a program which would stimulate creativity and the establishment of co-operative arrangements which would lead to better medical care for the region's inhabitants. The program has now reached a stage of development where it has achieved a level of acceptability that is second to no other similar agency in its field. Because of this, more proposals and ideas are coming into the office and more project appliactions are passing local review with subsequent submission for national review.

"Now, if the House action is indicative of what will eventually be the national funding policy for the near future it will directly affect the implementation of recent project applications, assuming that they pass national review, to the degree that there will be delays in attaining planned goals, or even worse that some goals may never be attained. Further any inability of the region to fund worthy projects will affect the credibility of the program and its representative officials. Lastly, a lot of the time and effort of the last three years devoted to getting people together, talking with one another, exchanging ideas with each other will have been wasted. Additional time and effort together with increased funds will have to be applied before the region once again reaches the present level of efficiency and acceptability."

ILLINOIS

The Illinois program, as Marilyn J. Voss, Public Information Assistant, indicates, has its share of funding problems:

"If RMPS does not get a larger budget appropriation—namely that seven IRMP projects approved with a budget of $611,106, will not receive the funds to enable them to be initiated. Thus, the Illinois Regional Medical Program would be operational in name only."

In addition, 14 doctors who have worked extensively in the program all signed a letter stating:

"We regard the inability to support the seven community projects now approved both by the Division of Regional Medical Programs and by the Council of the Regional Medical Program as nothing less than disastrous. This program was created by action of the Congress, and we as citizens in the State of Illinois were encouraged and urged to work together voluntarily and without compensation to create within the State a vigorous and strong organization capable of carrying the benefits of medical research to the patient. We have spent many hours and days in this undertaking. We are now faced with the prospect of having the Congress withdraw that support which it had assured us would be forthcoming. We should like to emphasize particularly that the seven projects approved are the first ones ever submitted by the Illinois Regional Medical Program to the Division of Regional Medical Programs for funding. Their preparation has involved many months of dedicated work by a large number of our finest citizens."

ILLINOIS AND MISSOURI (BI-STATE RMP)

The Missouri-Illinois Program, known as the Bi-State Regional Medical Program, has made great strides, and Dr. William Stoneman III, who coordinates the Program, reports:

"In two years a great deal of inertia has been overcome in St. Louis and the surrounding region. The two private medical schools are now working closely together. Both are making real community commitments beyond St. Louis which did not exist before. Southern Illinois University, which is in the process of developing a school of medicine, is participating. Project proposals have been approved and initiated to extend medical center capabilities to community hospitals and other groups throughout the region to improve the care available to the patient in his home community.

"At this critical point in time, a decision appears to have been made to cut back substantially on funding to the extent that essentially no funds for new activities will be available during the current fiscal year. The effect of such a policy on local initiative in our region will be very serious. Under those circumstances, the inability of this program to make any significant impact on the capacity of the health care system in the face of the massive federal infusions of money into health care demands (Medicare, Medicaid) is self evident."

INDIANA

Indiana would also suffer, as Dr. Robert B. Stonehill, its Regional Medical Program Coordinator indicates:

"Reductions in the Regional Medical Programs budget made by the House of Representatives, if carried over into actual appropriations legislation, will have a definite dampening effect on the Indiana Regional Medical Program.

"We now have a number of projects in various stages of development. All of them are aimed at regionalization of resources and services. If they are not

funded, momentum toward further regionalization will be greatly slowed. Further, the excellent beginning we have made in developing cooperative efforts will deteriorate and the initiation and development of new, worthwhile projects will come to a halt."

IOWA

Dr. George Hegstrom, Chairman of the Iowa Regional Advisory Group, indicates:

"Here in Iowa we have had much success in convincing practicing physicians, hospitals and other health persons and institutions that through the Iowa Regional Medical Program they have an opportunity to effect meaningful changes in Iowa's health care system in a way that is particularly appropriate and acceptable to the Iowa Region.

"A true cooperative spirit has emerged. Smooth and effective mechanisms for making decisions greatly representative of both the medical center and the community level are reaching a high level of development. The stage has been set. What a loss to the people of Iowa if this system for improving the quality of care at the place where people live is left to rot away from its lack of use."

KANSAS

The cooperative effort of Kansas would be weakened, as Dr. Robert Brown, Coordinator of that State's Program, shows:

"It is obviously disastrous to provide cooperative efforts for doing things at the Community Level only to have to report back to those groups that the Kansas Regional Medical Program will be unable to provide the financial assistance to carry out these Programs.

"Planning with a capability of doing has contributed greatly to the momentum of the Kansas Regional Medical Program. Fiscal restriction would undoubtedly dampen the enthusiasm of people at the Community Level to spend time and effort in a Program which cannot deliver the rewards for that effort expanded."

LOUISIANA

Dr. J. A. Sabatier who directs the Louisiana Medical Program, has eloquently stated the problem of the Louisiana Regional Medical Program:

"The lack of full funding of our initial modest package of operational projects would probably have a devastating effect upon the future effectiveness of not only the Louisiana Regional Medical Program but would probably also have an extremely deleterious effect upon future relationships between the public and private sectors in the health care delivery system. I seriously doubt whether it will be possible to ever again attract the degree of commitment and cooperative endeavor which has been accomplished thus far under RMP guidance. In short, I feel that the deleterious effects of the budget cut will be felt on a much wider base than the RMP Programs alone."

MAINE

In the State of Maine, Dr. Manu Chatterjee, Program Coordinator of the regional medical program, reports:

"At the present time, the Core staff of Maine's Regional Medical Program numbers nineteen. Programs for the staff are formulated with the assistance of committees and task forces representing virtually all organizations to include hospitals staffs. There is a major input into this program by both the providers and consumers of health services. The number actively involved in the planning process for this region is nearing 400.

"To date, we have been fortunate in having our programs approved; however, we are already feeling the pinch of the heavy financial constraints in the health care field. The following is a list of our present programs:

"Programs funded through September 30, 1970

Core staff grant	$578,807
Regional health agency (Upper Kennebec Valley)	241,745
Smoking control	48,626
Guest resident	36,391
Coronary care	198,462
Physicians' continuing education	76,285

"Programs approved by National Advisory Council, but not funded

Department of community medicine	$92,686
Directors of Medical Education	27,500
Regional cancer program	75,422
Regional library program	43,942

"(Plus appropriate indirect costs.)

"As we are progressing to a more efficient and experienced stage, it is anticipated that funding requirements for programs to increase the quality and distribution of medical care for the residents of Maine will more than double in the coming year.

"In order to maintain the impetus already gained by Maine, it is essential that programs approved by the Regional Advisory Council be funded within the next few months; otherwise, physicians, participating agencies, and all others assisting in the RMP effort will lose interest in project development since meaningful projects cannot be implemented due to lack of funds. We anticipate two more projects will be submitted for the December 1 deadline and would like to think that these projects will also be worthy of funding by the Division. You can see that already we need approximately $250,000 to implement the four programs that have been approved and the two other projects being developed for submission will require an additional $400,000. It is my personal opinion that Regional Medical Programs are just beginning to have an impact on the medical community at large and are making a major contribution to the health care of the nation and to this region in particular.

"Our particular program is presently funded through September 30, 1970, but it would be very helpful to have definite assurance that our present operations will be extended for a few years hence and that the present program will maintain enough flexibility to maintain 'an innovative approach' to health planning."

MARYLAND

The people of Maryland will also be hindered in their efforts to build a strong program, as Dr. William S. Spicer, Jr., the Coordinator reveals:

"We have numerous examples of this development in our Region, i.e., a central regional data and evaluation center, a coordinated development of comprehensive ambulatory care centers in our urban ghettos, which will assure all of the citizens of Baltimore of improved health care within the next 3–5 years, the change in community hospital structure to the corporate image, etc.

"Having established this base over the past three years, the Maryland RMP is now ready to provide solutions to the major health problems. This requires an expanded, not a reduced budget. It would be a terrible mistake to have expended rather modest amounts of monies, to be ready to go, and then to doom the Program at the moment when it is ready to move into full gear in catalyzing major changes in the health care system. The whole process would have to be reinstituted through some other mechanism. To be frank, I see no other effective mechanism."

MASSACHUSETTS, NEW HAMPSHIRE, RHODE ISLAND (TRISTATE RMP)

The Tri-State Regional Medical Program of the States of New Hampshire, Massachusetts, and Rhode Island may well be severely restricted, according to Dr. Robert P. Lawton, the Deputy Director. As Dr. Lawton states:

"What will be the effect of the low House appropriation on regions? Suffice to say that if this number is all that is appropriated the effect on Tri-State will be devastating.

"It is my personal judgment, if RMP were to have no more appropriation for 1970 than the House approved for grants, that it would be necessary to shut down some regions in order to keep the others alive. This is my national view. New England is potentially too important as an example of interstate cooperation, including effective coordination of RMP and CHP, not to warrant every possible regionalization dollar.

MICHIGAN

The State of Michigan's regional medical program will also be in severe difficulty. Here is the report of Dr. Albert E. Heustis, Program Coordinator:

"If these reductions are sustained, it will mean that in Michigan the following programs providing for improved health of the people of the state and which are ready to go will not be funded:

"1. A Comprehensive Health Care Program to serve the "urban poor" with cancer, heart disease, stroke, and related diseases in the vicinity of the Wayne County General Hospital and operated by that institution.

"2. Five interrelated acute stroke projects, including Wayne State University, Detroit General Hospital, Detroit Osteopathic Hospital Corporation, Sprarrow Hospital in Lansing and Michigan Heart Association.

"3. A training program for a new type of individual to assist nuclear physicians conducted by the Hackley Hospital in Muskegon.

"4. A program to provide continuing physician education for twelve smaller hospitals by the Blodgett Memorial Hospital in Grand Rapids.

"5. A cardiovascular educational program to improve patient care in the hospitals surrounding the Mercy Hospital at Benton Harbor, conducted by that institution with the cooperation of the University of Michigan through the Wayne County General Hospital.

"All of these proposals have been approved by the Regional Advisory Group as required by Public Law 89–239. Items 2 and 5 above have also been approved but not funded by the Federal Division of Regional Medical Programs. We are advised that the other items are in the process of receiving favorable federal consideration but that for them too, no funds would be available.

"This means that, if the figures recommended by the House of Representatives are enacted without change, the possibility of funding the projects listed above would be prohibited as would the development of additional new projects to provide Michigan people with the improved health envisioned by the Congress when they enacted this legislation. This shattering impact will come at a time when the initial inertia and suspicions surrounding the Regional Medical Program are being overcome, and when people are beginning to trust each other and work together for improved health as a result of the stimulation provided by federal funding."

MISSISSIPPI

In the South the problem is equally severe: Dr. Guy D. Campbell, Coordinator of the Mississippi Regional Program, says that the House action will have the following effects in that state:

"The reduction would cause the program to drop from its leadership position in the stimulation and implementation of new programs to meet old needs to a neutral or at best a "holding" position.

"The program wil lose its hard won momentum and most significantly, the confidence of the medical community and others.

"The reduction will have a negative effect on core staff morale and will probably contribute to staff turnover.

"Due to the devastation of Hurricane Camille in southern Mississippi, the State Legislature appropriated ten million dollars for loans and grants to aid in the reconstruction of whole communities in that area of the state. This appropriation and a concurrent shift of funds by many state and private agencies to assist in this rebuilding program has significantly reduced the availability of monies that could have been used for participation in the Mississippi Regional Medical Program.

"If the trend of RMP is toward decategorization and primary care, any reduction in funding would threaten the achievement of this goal.

"Should the Division of Regional Medical Programs be required to make an across-the-board cut in funding for all regions, certain projects already funded at a base minimum could not sustain a reduction without severely compromising their primary objectives of patient care, continuing education, training, etc."

MISSOURI

The Regional Medical Program in Missouri will lose momentum, according to Dr. Arthur E. Rikli, Coordinator:

"The curtailment of funds at this time will result in a serious break in confidence with communities who have been earnestly working toward the development and expansion of services for heart, stroke and cancer patients. Communities such as Sikeston, Lebanon, Joplin and others were anticipating the technical and financial assistance from the Division of Regional Medical Programs to test improved cooperative arrangements leading to regionalization of health services. There will be a serious loss in our momentum to carry out this Program if the Senate does not restore funds cut from Regional Medical Program by the House."

NEBRASKA, SOUTH DAKOTA

Dr. Harold S. Morgan, Program Coordinator reports that the Nebraska-South Dakota Regional Medical Program probably "will not be able to survive":

"If the Regional Medical appropriation recommended by the House is sustained, the Nebraska-South Dakota Regional Medical Program will not become operational. Four projects have been approved by Council in the sums of $1,017,692. This sum together with the awards approved for 6 other regions will far exceed the amount of new money available.

"The result of the failure to fund our approved projects will be so disastrous to the Nebraska-South Dakota Regional Medical Program that it will not be able to survive, and without survival, the program will not do what PL 89-239 was intended to do when Congress passed the law."

NEW HAMPSHIRE

In New Hampshire, Hamilton S. Putnam, Executive Director of the Program states:

"There is cause for concern that, unless the Senate establishes a higher funding level for Regional Medical Programs above that voted by the House and a Committee of Conference concurs with this larger figure, the national effort of RMP—just now beginning to evidence its potential thrust—will be in jeopardy."

NEW JERSEY

Dr. Alvin A. Florin who coordinates the New Jersey Regional Medical Program says that the cooperative arrangements there will be discouraged:

"Specifically, a decrease or leveling of funding will delay the funding of an operational project already approved which provides for the development of health activities in ghetto areas through assignment of urban health planners to Model Cities programs. New Jersey has nine federally funded Model Cities programs, and the problem of supplying needed medical services to ghetto residents is acute both in quantity and quality of delivery.

"Generally, a decrease or leveling of funding will diminish the impetus of our program by discouraging the development of operational grant proposals. Further, it will discourage cooperative arrangements because of general pessimism regarding the future of the Program."

NEW MEXICO

New Mexico's Program would "suffer a subtle Program deterioration" as Dr. Reginald H. Fitz, its Director, reports:

"Beyond the identifiable or specific negative impact of a 'new funding freeze,' which is what would result if funds are not restored to the Division's budget and a reasonable competition for them re-established. I believe that there would be a more subtle Program deterioration. The New Mexico Program is, I believe, in a very strong growth position. It is receiving increasingly enthusiastic interest and support. The relationship with the University is excellent and cooperative recruiting has succeeded in attracting exceptionally well-qualified professional personnel to the Core Staff and operational projects. If the Program should lose the momentum that it has so recently achieved and were continued progress to be made impossible due to lack of funds, I am afraid that the Program would lose its ability to attract or retain able individuals and would fail to reach the level of significance in relation to the solution of health problems in New Mexico that lies within its conceptual capability. To use an obvious analogy, undernutrition at this point would seriously stunt the growth of what appears to be a very healthy child."

NEW YORK (CENTRAL)

The Central New York Program faces difficulties, as Dr. Richard H. Lyons, Coordinator of the Program, reports:

"The decrease in funds has not paralyzed our present operational approaches but has greatly decreased the enthusiasm that was beginning to be generated among members of the health professions for the Program. In fact, a number of projects which were under consideration have simply been side-tracked because of the lack of funds and others have been approved by the council and have not been developed for the same reason."

NEW YORK (METROPOLITAN)

The gloom surrounding project cutbacks in the Metropolitan New York RMP is reported by Dr. I. Jay Brightman:

"The NYMRMP was recently approved for operational status but cannot be funded as such, because of the cutback. When the applicants heard the news that their projects were approved but unfunded, their reaction was more serious that if the projects had been rejected. In the latter situation, they might have become indignant, but they also might have taken the attitude that a better application might be approved. In the present situation, they have been completely discouraged. It has been a long period since their applications were first drafted, processed through our staff reviews, our technical consulting panels and our RAG to begin the trek up to the National Site Visit, the study by the Review Committee and finally the action by the National Advisory Council on Regional Medical Programs. Having survived all this, they are little consoled with the moral victory and the less than certain chance for future funding.

"The same gloom has spread among all of our Associate Directors in the seven medical schools and the Regional Medical programs operating there. There is little incentive to actively pushing projects fairly well along the course of development when they feel that they do not have an even chance of having highly meritorious work adequately financed."

NEW YORK (WESTERN)

Dr. John R. F. Ingall, Program Coordinator for the Western New York program headquartered in the State University of New York at Buffalo reports:

"In the Western New York Regional Medical Program we already have in effect projects that have identified us highly favorably with the community, not only in our ability to provide continuing education for ALL facets of health allied personnel, but also to upgrade the standard of medical care by devising cooperative ventures.

"Let me be more specific than the foregoing: we have a coronary care training school for nurses, of 6 weeks' duration, which, in my view, is of the highest quality available in this country. It not only provides 6 weeks training for nurses from the didactic and practical point of view but serves as a consultation point and support center for nurses in the entire region. We are producing a caliber of nurse to whom the local physicians will delegate responsibility. The physicians of the region, in turn, enjoy the experience of training within this school and what was originally considered a doubtful training entity has now become one of the most popular of our continuing medical education courses. Nurses in our school have already saved life and in one case resuscitated one of our own physicians! The value of this to the program's image alone is fantastic.

"This Program, as you know, has a very large Regional Advisory Group represented by a 24-man Board. The reduction of funds to a Program such as this, which has good identity and major cooperation from the region at large, would be disastrous.

"For the first time in the history of this region we have developed a true consortium of private, V.A., county and university affiliated hospitals that has never before existed.

"Our telephone lecture network links up all these units and permits conference discussion which is logistically impossible, certainly in winter months, and saves a great deal of money in time and human effort in that the entire region can come together through this conference mechanism without leaving their own particular hospital center.

"We have calculated that with the goodwill built up and the voluntary time donated to this Program, the region at large is currently giving 25 cents for every dollar contributed by the federal government, which is not a bad contribution. I anticipate that this will increase in its dimensions and would suggest that if federal monies continue, or indeed are increased, then ultimately we can structure ourselves as an independent and economically viable organization for which federal monies would be unnecessary. The money to bring this about, however, is vital and it behooves us to put the transition into perspective of time. This cannot be just done in the incumbency of one administration.

"More briefly, should the funds be cut in this area I visualize the following:

"(a) The discontinuation of a superb coronary care training school;

"(b) The dissolution of the first inhalation therapy school for chronic respiratory diseases centered on a community college in this area; a system of true regional support in respiratory diseases available to all communities, small or large, on request which has been a singularly effective support entity to the practicing physicians.

"(c) The education groups in this paramedical sphere, namely dietitions, pharmacists, dentists, hospital administrators, medical record librarians, and a number of others will be unable to continue their accreditation programs via our telephone lecture network, and the upgrading of these groups in their standards and responsibilities will receive a very serious blow.

"If Comprehensive Health Planning is really to get off the ground in this region it needs the support of the Regional Medical Program, for the latter has predominantly been responsible for the surveys and data collection. We are able to perform the latter in that we have not only the university support and that of the local county and state Health Departments but an ever-increasing involvement of the voluntary agencies, the private sector and the hitherto poorly acknowledged consumer group."

OHIO (NORTHEAST)

In Northeast Ohio's RMP, Dr. Barry Decker indicated crippling of that Program.

"We are now functioning on a second year planning grant which expires June 30, 1970. As a result, there have been no immediate effects resulting from the present budget cuts. We are, however, bringing together a series of grant applications to be submitted to the Division, prior to December 1, which summarizes and results from eighteen months of hard work. These requests should include between two and three million dollars per year of grant applications including our subsequent core staff support. It would appear to me that, in the present situation, the Division will have funds for no more than our continuing core staff support, which in effect will cripple the Program in Northeast Ohio."

OHIO (NORTHWESTERN)

Northwestern Ohio's Regional Medical Program is not different, according to C. Robert Tittle, Jr., Coordinator.

"If the House reduction is maintained by the Senate we could expect that the three proposals which we have now undergoing review, by the Division of Regional Medical Programs, and six (6) proposals which are to be submitted December 1, 1969, for funding, perhaps two of the nine might be funded, but at a greatly reduced rate; we anticipate these two (2) would be funded at a 50 to 60 percent rate. We, also, anticipate that our present six (6) operational proposals will not continue to be funded even at the 75% rate, but at a reduced rate of 60%. You can well understand that we cannot maintain participation or enthusiasm when projects are approved but no funds are available."

OHIO (STATE)

The Ohio State Regional Medical Program fares just as badly, as Dr. Neil C. Andrews reports:

"Much energy by our dedicated core staff has been expended among health professionals within the Ohio State Region in the development of cooperative arrangements. Continuous attempts have been made to indicate to physicians and other health professionals that this is not an attempt by the federal government to take over the practice of medicine. Workshops have been conducted for health professionals and interested citizens; regular meetings have been held for Local Planning Chairmen and Committee Members to acquaint them more thoroughly with the goals and objectives of the Regional Medical Program. Multiple articles have been written and distributed along with newsletters to a wide audience in an attempt to gain better understanding of the Program. All of this patient, methodical, painstaking development of confidence and respectability for the Program is in danger if the Program is seriously retarded."

OKLAHOMA

Dr. Dale Groom, Director of the Oklahoma Regional Medical Program reports:

"As I see it, this major retrenchment in Regional Medical Programs on a national scale is not only a backward step but, more important, it undermines years

of planning and effort on the local scene not only by RMP but by all the other health agencies with whom we try to work. There is no question but that Regional Medical Programs were over-sold in the flush of enthusiasm when Congress appropriated sums exceeding those which the infant organization could assimilate. One cannot simply turn on well-conceived and well-planned health programs overnight. Recruiting and training medical manpower requires more time than opening up new offices. At any rate, fledgling RMPs sought out leading citizens and educators to constitute their Advisory Boards; their staff went out to communities throughout their regions to solicit and organize cooperation of local health resources; surveys were made of health needs; medical associations, hospitals, nurses and paramedical personnel were brought into the councils of the brave new endeavor. And now because of cutbacks which could hardly be foreseen, we are unable to follow through on the collaboration and, in many cases, the promises which were extended in good faith. Really, this strikes at the integrity of the whole effort. If we fail now, it will be doubly hard to take up the cause again at the same high level. Moreover, I am sure we will begin to lose our greatest capital of all, namely the quality of leadership and the good name which Regional Medical Programs have built up in their brief ascendency.

"I believe that now it is evident to all of us in RMP that we are at a decisive crossroads, that this year is crucial, that we cannot stand still but must go one way or the other. Actually what we need for success in this health effort is only a tiny fraction of current non-health expenditures of our country. I am hopeful that our national sense of values will prevail and that the support necessary for the success of this most important national resource will be restored."

TENNESSEE

The Tennessee Mid-South Program, as Dr. Paul E. Teschan, Director reports, will be in trouble if it does not receive needed funds:

"Five projects amounting to $274,000 are being held in abeyance and options for employment of key personnel are being lost. Since these projects will be activated in the *region* (as contrasted with projects located in or deriving principally from the university centers in Nashville) this major regional thrust is being blunted, with continuing serious injury to the image of the Program as a *regional* one.

"The budgetary restrictions coupled with the reports in the press and the speculations in the 'Blue Sheet' of which we are all aware have raised an undercurrent of speculation in this region concerning the projected viability of RMP locally and nationally. Among practicing physicians, hospital administrators and the allied health professionals in the region, among whom the tide of interested acceptance of RMP is mounting, we perceive a damaging cynicism concerning the trustworthiness of even this federal program. For the more knowledgeable individuals, who perceive that there is no visible alternative to RMP in linking university centers and the provider structure, a sense of bitterness and incredulity can also be detected. The latter development is particularly underscored when approval for a nuclear aircraft carrier, multiple landings on the moon, and an antiballistic missile system of dubious workability seem to get by relatively easily.

VIRGINIA

For the State of Virginia, Dr. Eugene R. Perez, Director of the Program reports:

"Relative to the reduction of the Regional Medical Programs budget, I believe it is obvious that it will result in definitely curtailed activity of the Program in Virginia. With less money to operate, obviously one will be able to do less. Unfortunately, this will be a strain on all concerned, as it will be necessary to set strict priorities.

The most unfortunate aspect, I believe, is the timing of the budget cuts. I think that all regions have had pretty much the same experience, and I know that it has taken two to three years in Virginia to get the confidence of the various groups, and to establish the necessary cooperative arrangements. We have accomplished the foregoing in Virginia, and now that we are ready to spread out and make the Program effective it will be difficult because of less money. I am afraid that this will blunt the momentum of the Program.

In summary; less money, less Program, less interest, less participation, and less effect upon improved patient care of the citizens in the region."

WEST VIRGINIA

Charles D. Holland, acting Director of the Program in West Virginia reports:
"To answer the question in your recent memorandum of the effect on the West Virginia Regional Medical Program of the House cut in Regional Medical Program funds for 1970, I can only report that we have been recommended for operational status beginning January 1, 1970—but have not been funded. I believe that our entire Program is in jeopardy because of the House action."

WISCONSIN

In the State of Wisconsin, Dr. John S. Hirschboeck reports that:
"The Wisconsin Regional Medical Program has two proposals under review and awaiting funding by the Division of Regional Medical Programs. Each of these will have little chance of being funded if the appropriation bill is passed by the Congress at the level recommended by the House. One of these projects is budgeted at $664,374 for its first year. It is concerned with the development of a comprehensive approach to managing chronic renal disease. It includes support for home dialysis training for patients and their families and the development of a transplant strategy to provide rapid matching and transplantation within a few hours. The second project will require a first-year budget of $999,229 for the operation of a health profession manpower improvement and expansion program in the Greater Milwaukee area. The purpose of this project is to provide a variety of in-service training experiences for physicians and others to learn new technology and to develop working skills for people who presently do not have them. Both projects have great implication for the improvement of health care in the Wisconsin region. With the limited funds which would be available under the appropriation recommended by the House, these obviously will have little chance of being funded.

The flexibility and readiness of Regional Medical Programs to deal with major health problems are, perhaps, their greatest asset. However, without funds to demonstrate their capability, Regional Medical Programs are apt to fall before they really have had a start."

The CHAIRMAN. I just received a statement from Mr. Kenneth Williamson, deputy director, American Hospital Association, which I order printed in the record at this point.

(The statement referred to follows:)

PREPARED STATEMENT OF KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

This statement is directed to you to present the views of the American Hospital Association on two bills which are presently under consideration by your committee.

One of the bills, S. 3355, the Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970, which you introduced, deals in the main with the future of the Regional Medical Program and provides a five year extension of this program with a number of significant changes.

We strongly supported the development of the original Heart Disease, Cancer, and Stroke legislation and have in numerous ways encouraged the participation and cooperation of the hospitals of the nation in the program. Viewed in the context of its potential significance, this program, which is known as the Regional Medical Program, has had a relatively short life to date, and it is too soon to for many complete judgment as to its effectiveness. We continue to believe the program has great promise and we support its continuation for a five year period. We believe the Congress acted wisely in limiting the program to the specific disease categories named in the original legislation. Such an approach directed major attention to three disease entities which are of concern to the entire population. The statement you made, Mr. Chairman, when you introduced S. 3355, succinctly sets forth the very laudable purpose of the Regional Medical Program as envisioned in Public Law 89-239. You said that in the law, "Emphasis was placed on the development of cooperative arrangements among the providers of health care to improve the quality and availability of care". We believe this

means getting care to the public and speaking candidly must point out that the program is far from accomplishing this purpose. We, therefore, seriously question the wisdom of bringing additional major disease categories into the program, thus diffusing the effort, until there has been much greater demonstration of accomplishment of the basic purpose intended by the original legislation.

We are pleased to note your bill provides for contract as well as grant authority to carry out the Regional Medical Program, and we also think it is desirable to include prevention and rehabilitation as integral parts of the program, as your bill would do.

With regard to the provisions of S. 3355 dealing with the composition of regional advisory groups for local regional medical programs, we agree that official health and planning agencies should be represented on such advisory groups. We fully support the provisions of your bill in this regard.

Turning to the National Advisory Council on Regional Medical Programs, we also support fully the requirement in your bill that "health care administration" be represented on the National Advisory Council. It is highly essential that the knowledge and experience of individuals intimately associated with the organization and administration of health services be named to the Regional Medical Program National Advisory Council.

We have for some time been quite concerned about lack of coordination of activities under the Regional Medical Program and the Comprehensive Health Planning and Public Health Service Program. We feel that Section 7 of your bill provides an important initial step in the coordination of these two programs by requiring Section 314(b) areawide planning agencies have the opportunity to consider Regional Medical Program applications before they are recommended for approval.

Before your Committee also is the Administration's Health Services Improvement Bill, S. 3443, which was introduced by Senator Javits. It is pertinent to note at the outset that this bill is much broader in scope than S. 3355. In fact, S. 3443 deals with four health programs—the Regional Medical Program, the Comprehensive Health Planning and Public Health Services Program, as well as the Health Services Research and Development Program, and the activities of the National Center for Health Statistics.

The bill completely rewrites Title IX of the Public Health Service Act, decategorizing the Regional Medical Program and establishing broader goals for it. The language in the present law which states regional medical programs must not interfere with existing patterns in the organization of physician services has proved to be detrimental to the development of the program and has hampered the achievement of the goals established for the program. We therefore, strongly approve the elimination of such restrictive language as provided for in S. 3443.

At the present time hopsitals are frustrated by the duplication and overlapping authority existing in the Comprehensive Health Planning and Public Health Services Act and the Heart Disease, Cancer, and Stroke Act. The manner in which these two programs are presently being operated encourages competitive activities for domination of the field. We are glad that S. 3443 recognizes the potential conflict existing at the local, State, and Federal levels. However, we reiterate our strong belief that every effort should be made to eliminate the existing overlapping and confusion, and we would urge that the law be amended so that planning under the two programs will be brought into conformity.

We note that S. 3443 would provide for review and comment on Regional Medical Program operational grant applications by both State and areawide health planning agencies. The bill also provides for Regional Medical Program representation on State and local Comprehensive Health Planning Councils and requires official health planning agency representation on Regional Medical Program Regional Advisory Councils. Further, the bill would establish a single National Advisory Council on the Planning, Organization, and Delivery of Health Services which would be assigned extremely broad responsibilities for coordination of numerous health programs, including the Regional Medical and Comprehensive Health Planning and Public Health Service Programs. All of these provisions of S. 3443 are important steps in the coordination of these two programs.

Section 922 of S. 3443 provides authority for project grants to State Comprehensive Planning agencies to allow them to provide assistance in the development of comprehensive health plans with respect to areas not otherwise supported by areawide planning grants. This provision, we feel, is a valuable improvement.

We approve the proposal for establishment of a National Advisory Council having authority over the Comprehensive Health Planning and Public Health Services Program. The lack of such a council is a serious deficiency in the present law. Under S. 3443 the present Advisory Council for the Regional Medical Program would be eliminated. The proposed new National Advisory Council on the Planning, Organization, and Delivery of Health Services would function in respect to all programs under the new Title IX of the Public Health Services Act. The language of the bill describing the role and function of this proposed National Advisory Council is so broad and encompasses so many other health activities in which the Federal Government is involved that we become concerned as to whether the Council can be effective. We further note that there is no provision in the bill for an advisory council to review and recommend the approval of grants at the national level prior to the making of grants under these various programs. This we feel is a serious shortcoming.

The proposal of the Administration contains a number of most desirable provisions which could contribute importantly to the development of better health services throughout our nation and which would without doubt be in the interest of the public. Several committees of the Congress are struggling with the problem of inflation of health care costs and are looking to the legislative proposals before your committee to provide assurances in respect to sensible health facilities and services programs. We strongly endorse the development of planning pertaining to the health field. However, we must express our deep concern that here again the Administration is offering a lot of great promises to the public, but on the other hand appears to be unwilling to request appropriation of the funds necessary to fulfil such promises, as reflected in the Fiscal Year 1971 HEW budget submitted to Congress last month.

We appreciate the opportunity of expressing our views on these bills and request this statement be made a part of the record of your committee's hearings on them.

The CHAIRMAN. The hearings will be recessed until 9 o'clock tomorrow morning.

(Whereupon, at 12:05 p.m. the committee was recessed, to reconvene at 9 a.m. Wednesday, February 18, 1970.)

HEART DISEASE, CANCER, STROKE, AND KIDNEY DISEASE AMENDMENTS OF 1970

WEDNESDAY, FEBRUARY 18, 1970

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Ralph W. Yarborough (chairman of the committee), presiding.

Present: Senators Yarborough (presiding), and Eagleton.

Staff members present: John S. Forsythe, general counsel; James Babih, professional staff member to the subcommittee; and Jay B. Cutler, minority counsel to the subcommittee.

The CHAIRMAN. The Subcommittee on Health will come to order. Hearings are resumed on S. 3355 and related bills. We had testimony on them yesterday. Also, some testimony was given on an administration bill that has just been introduced the day before. They were late introducing it.

We have a request that Dr. Farber be called first.

STATEMENT OF DR. SIDNEY FARBER, CHAIRMAN OF THE STAFF, CHILDREN'S HOSPITAL MEDICAL CENTER, BOSTON, MASS.

The CHAIRMAN. Dr. Farber, you may proceed in your own way. I notice you are chairman of the staff of the Children's Hospital Medical Center, Boston, Mass.

First, I want to commend you on your work at that center. That center and the Harvard Nutritional Studies combined to work with children. They have been of special value to the Special Committee on Malnutrition, Hunger, and Health of which I am also a member.

The studies have been of great value to that subcommittee. I hope they awaken the conscience of the Congress and the country to where, within a year or two, we can place enough food on the tables to end malnutrition and hunger.

Dr. FARBER. That would be a great achievement, Mr. Chairman. We are grateful to you for the part you are playing in bringing that about.

It is a privilege once more to testify before this committee, with particular reference to the one bill that I have had an opportunity to study with care, the bill sponsored by you, Mr. Chairman, and your colleagues, S. 3355.

May I speak first in strong support of the bill S. 3355 which will make possible the continuation and expansion of the regional medical programs.

These arose from the recommendations of the President's Commission on Heart Disease, Cancer and Stroke in 1965. From intensive study of the questions which concerned that Commission, as a member of that Commission, and on the basis of 43 years of personal concern and broad intrest in the field of medicine as a whole, with more specific interest in the field of cancer, I subscribe wholeheartedly to the broad goals of your bill.

This can be described in a sentence, the utilization of the knowledge and expertise we have in the treatment of every patient in the country, wherever he may be, with eventual expansion to all disease, but beginning at first in the areas of heart disease, cancer and stroke, and now kidney disease.

The regional medical programs were designed to develop on a regional basis connecting links between the centers of expertise in universities, teaching hospitals and research institutions, with the community hospitals for application of the results of research to the patient as quickly as possible; for the demonstration of new methods of treatment; for the continuing education of doctors in the community hospitals, and for the generation of new knowledge of importance to the patient, combining in this way programs concerned with the prevention or eradication of disease with much more rapid application for the good of the patient everywhere.

There are no more important goals for the good of the people as a whole than those embodied in the regional medical programs.

Correctly applied, they will mark, for the first time, the availability of the highest degree of excellence in the care of all our citizens.

With your permission, I would like to speak specifically to a few points raised by the bill which perhaps can strengthen the areas of greatest concern in my own observations.

First, the extension of the goals. The present bill calls for extension of the diseases covered by regional medical programs.

I am heartily in accord with the addition of kidney disease. As a doctor and as a citizen, I am, of course, deeply concerned about improving the lot of all patients suffering from any kind of disease.

The only reasons which I could defend for restricting the onset of this program to heart disease, cancer and stroke, and now kidney disease, concern also with pulmonary disorders, including also diabetes, as is already the case, are, first, the fact that these diseases account for more than 70 percent of all deaths.

These are easily identified and serve well for the building up of experience in handling a new concept on a regional basis.

As soon as sufficient experience is attained with these programs, it is my earnest hope that all disease will be contained in the regional medical programs on the same basis, with the support of sufficient appropriations to extend these programs in such a manner that the relationship to comprehensive medical planning with regional medical programs will hopefully be a close one.

The slow progress so far in developing the regional concept all over the country, in all regions, would lead me to suggest that the judgmental processes in allocation of funds for grants be not further delayed or complicated until regional medical programs have worked out a much more efficient system than has been the case so far. This appears to be within our grasp.

The second point to which I would like to speak concerns the construction of centers of excellence, or expertise, as originally described in the President's Commission report and already discussed on a number of occasions before congressional committees.

I would like to support strongly the inclusion of funds for the construction of research facilities in the field of cancer and the other fields with which you are concerned in your bill.

These funds would be in addition to those which are recommended already for grants and for contracts. The studies of the Presidential Commission in 1965, and of subsequent committees of the National Cancer Institute, and the American Cancer Society, have called for the recommendation of construction funds to expand present cancer centers and to erect new ones in at least 20 locations of the country where there are centers of population.

Such construction should be additive wherever possible to the facilities now available so that we will make full use of those facilities which are already available. Such construction support has been recommended by the Citizens Committee of the American Cancer Society, speaking to the appropriation of the National Cancer Institute, for the past 5 years. But, unfortunately, no money has been appropriated.

The invaluable Hill-Burton-Harris construction funds are designed primarily for hospital beds and do not make allowance for the needs embraced in this bill, nor is a sum available for the Hill-Harris construction large enough to meet the needs of this program, too.

Until such centers are built throughout the country, the full force of the regional medical programs cannot be brought to the good of the community hospitals and, through them, to the patients, all patients with cancer, to speak specifically to the problem of cancer and not to the exclusion of any of the other major disorders.

I would like to speak a word, too, to the recommendation for construction of educational and ambulatory space and other clinical facilities in the community hospitals. Equally important is the receiving and further delivery of the regional medical programs in the community hospitals, where there must be space provided which the community hospitals cannot provide themselves for the specialized clinical facilities needed to carry the most expert forms of treatment of cancer to the patient in the community hospital, and also for he continuing education of the doctors in these community hospitals, with the help of this new relationship of cancer centers, made possible by extension and expansion of the regional medical programs under your bill.

I speak of this for cancer, but it is equally important for heart disease, stroke, and kidney disease, and the other major disorders as they come along when more money is available.

In closing, Mr. Chairman, and gentlemen of the committee, I would hope that the regional medical programs would remain an identifiable, viable entity that will cooperate to the full with comprehensive medical planning, with the programs of the National Cancer Institute and the other Institutes of Health in Bethesda, which are concerned in carrying out its mission without duplication or unnecessary competition with other important programs concerned with the health of our people.

I would hope, too, that, as the excellence of the regional medical programs become apparent and the needs clearly justified, appropriations adequate for the task will be made available through your action.

I would like to add one final word. I would like to make a suggestion which might strengthen the bill. You have already strengthened the previous bill in many different ways in the bill before you.

I would like to make a recommendation to the committee to strengthen section 2 of the bill which starts on line 16 of page 6. Provision is made there for certain research and training activities in chronic diseases which are necessary and vital, but no administrative structure is provided in the language of the bill.

Moreover, no specific amount of money is set aside for these purposes. I would suggest that a section be written into the bill which would provide an administrative structure for these programs.

I would like to recommend that the structure in which they now reside be the one which would continue to administer them.

That is, the Chronic Disease Division. The Chronic Disease Division would be authorized to develop and conduct field trials and clinical investigations, establish programs for the training of professional and technical personnel, establish trainee and fellowship programs, support epidemiological studies and support programs providing health services for the diagnosis, treatment and prevention of heart disease, cancer, stroke, and kidney disease, and other diseases relating to these major disorders.

I would also recommend authorization of an appropriation of at least $50 million per year for funding these programs for as many years as the committee decides to extend the legislation.

Mr. Chairman, I would like to express my gratitude to you and to the Members who are cosponsors of what I regard as one of the most vital pieces of legislation in the history of our health services to our country.

The CHAIRMAN. Thank you very much, Dr. Farber.

I am instructing the staff to get those specific recommendations for improvement into the legislation.

Dr. Farber, I take it from your testimony that you do not agree with the presentation made by Dr. Egeberg, Assistant Secretary for Health and Scientific Affairs in the Department of Health, Education, and Welfare yesterday when he said, "We oppose the provisions of S. 3355 which would authorize new construction of demonstration, research and training facilities."

The administration flatly opposes new construction. You do not agree with that?

Dr. FARBER. I didn't hear him, but I understand that is his point of view. I could not agree with him on this.

The CHAIRMAN. I think you have made a very strong case for the need for additional centers, not merely just the continuation of the present ones. I believe you said 20 more.

Dr. FARBER. Yes. This has been as a result of careful study for a number of years. The number 20 would fit the major population centers of the country where this kind of expertise is more necessary.

The CHAIRMAN. I have been a member of this health subcommittee for 12 years now, and during that time I have heard much testimony about the excellence of the M. D. Anderson Clinic at Houston, the

Mayo Clinic in the Midwest, and the facilities of Johns Hopkins in Baltimore.

Is there any comparable city center on the west coast for treatment, do you think?

I don't mean those are the only three in the country, but it seems to be the general medical consensus that each of those are very superior.

In the field of cancer research and treatment, is there a comparable facility on the west coast that would equal the expertise and services combined in these three?

Dr. FABER. There are a number of excellent university-based centers on the west coast. Nowhere on the west coast, however, is there anything as large as the M. D. Anderson in Houston, the Roswell Park in Buffalo, or the Memorial-Sloan Kettering in New York. Those are the three largest in the country.

The CHAIRMAN. The Roswell Park?

Dr. FARBER. The Roswell Park Cancer Institute in Buffalo, N.Y. It is supported by the State of New York, in part, and, in part, by large grants through the National Cancer Institute and the American Cancer Society, as are the other two large centers.

In San Francisco, at the University of California Medical School, there is a cancer institute as part of the medical school. It is not nearly as large. They are, however, doing very fine and effective work.

At the Stanford University Medical School in Palo Alto, there is a superb cancer effort, mainly in the field of radiotherapy and related techniques, with a very fine exerimental research program.

In Boston, we have a smaller cancer center with which I am associated, affiliated with the Children's Hospital Medical Center, called the Children's Cancer Research Foundation, which has about 650 children for cancer treatment at any one time, and a very large research program. This is being expanded at the present time by the addition of a large cancer center for adults in the spirit of the original regional medical programs plan.

This is being done with private funds because of the unavailablility of Federal funds for this purpose at this time.

So we will have, in addition to all of the other research and care programs in the many Boston hospitals associated with the three Boston medical schools, and the other excellent medical schools in New England, one large concentration for adults and children in Boston within 2 years.

The CHAIRMAN. Thank you very much. I think, Dr. Farber, you have made a very strong case for the necessity of continuation of construction.

You mentioned 650 children average at a time in that cancer center for children in Boston. What percentage of those suffering from cancer would be suffering from leukemia?

Dr. FARBER. Roughly 45 to 50 percent.

The Chairman. And the others?

Dr. FARBER. Mostly of the kidney, of the adrenal, of bone, of the intestinal tract, and so on.

The CHAIRMAN. Small children have all those various types of cancer in addition to leukemia?

Dr. FARBER. Yes. It is not nearly as common a problem as in the adult. Cancer increases markedly with age. But between the ages of 1 and 14, cancer is the leading cause of death among the diseases.

The CHAIRMAN. Among children of that age?

Dr. FARBER. Yes. Not from birth to 1, but from 1 to 14.

The CHAIRMAN. From 1 to 14, cancer is the leading cause of death of children in that age bracket. That is an important fact for the committee to have in consideration of this bill.

I take it you do not agree with the statement presented yesterday that this program for regional medical centers to combat heart disease, cancer, stroke, and kidney disease be merged with the other programs and amalgamated.

Dr. FARBER. Mr. Chairman, I agree with you. I think it would be exceedingly unfortunate if regional medical programs were merged or submerged, which is actually what would happen. The Cancer Institute program has to do with the generation of new knowledge through research. The regional medical programs have to do with the saving of lives.

We are talking about causes of death. More than 70 percent of the deaths are caused by these. We are talking about getting what is known in the centers of expertise and research as rapidly as possible without delay to the patient in the community hospitals, wherever the patient may be in the country.

In the comprehensive medical health planning we are talking about not deaths, necessarily; we are talking about illness.

All three are extremely important. Each one must be expanded to the fullest ability of our financial structure in this country. But each one must develop to achieve its own goals. We must not permit a confusion of this comprehensive health plan with something that is so clearly identified and goal directed in the prevention of death as the regional medical programs.

The CHAIRMAN. Thank you. Your testimony is very helpful to this committee, Dr. Farber.

Dr. FARBER. Thank you, sir.

The CHAIRMAN. The next witness is Dr. John S. Meyer, professor of neurology, Baylor College of Medicine, Houston, Tex.

STATEMENT OF JOHN STIRLING MEYER, M.D., PROFESSOR OF NEUROLOGY, AND CHAIRMAN, DEPARTMENT OF NEUROLOGY, BAYLOR COLLEGE OF MEDICINE, HOUSTON, TEX.

Dr. MEYER. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Meyer, we welcome you to this subcommittee, which is continuing its hearings on S. 3355 and related measures.

We appreciate your taking the time to come here to testify. We know how difficult it is to travel this time of year and we appreciate your coming before the committee.

Dr. MEYER. Mr. Chairman and members of the committee, thank you for the opportunity to speak in support of S. 3355, a bill incorporating amendments to heart disease, cancer, stroke, and kidney disease, in 1970.

I am also pleased to be testifying as chairman of the Council on Cerebrovascular Disease of the American Heart Association which is deeply concerned with this bill.

I would like to testify in accord with other doctors that have given you their opinion that this is a very vital national health program which is going through a critical time and needs the support that this bill will provide.

I will speak here about the continued support of the categorical nature of this program. Perhaps I can do this best by citing the importance of stroke, which has been my area of special interest for the past 20 years.

I was formerly director of one of the first national stroke centers in Detroit in my previous position as professor and chairman of the department of neurology at Wayne State University and now I have moved to Houston, Tex., where I am actively engaged in developing a new stroke center at Baylor College of Medicine which is to be combined with the famous cardiovascular center under the direction of Dr. Michael E. DeBakey.

To give you some background of my interest in the area, perhaps I should mention that I was chairman of the Stroke Subcommittee of the Commission that originally advised the creation of the heart disease, stroke, cancer, and kidney disease program of the regional medical programs.

With these introductory remarks, let me now proceed to defining briefly the tremendously important area of stroke which, as you know, accounts for the third most important cause of death in this country and probably is the greatest disabler of all diseases since there are 2 million people in the United States who suffer from residual paralysis, disturbance of mental activities, or speech, as a result of a stroke.

A stroke may best be defined as a disorder of brain function due to some impairment of circulation to the brain. This may be due to hemorrhage into the brain due to high blood pressure or it may be due to rupture of a cerebral vessel due to weakness of the vessel wall caused by an aneurysm—which is like a blister on a tire which blows out—or by embolism of the cerebral vessels from impaction of them by blood clots which break off from the heart due to heart disease or by thrombosis within the narrowed cerebral vessels due to hardening of the cerebral arteries.

This disease stroke-causing catastrophic injury to the brain, affects young people as well as old.

I would like to reemphasize this point. This affects young people as well as old. This is not a disease of old people.

Let me cite, for example, two tragic deaths due to stroke which occurred in the past month. Dr. Maitland Baldwin, the famous neurosurgeon and director of neurosurgery in the intramural program of the National Institute of Health Hospital died of a stroke due to a ruptured aneurysm at the age of 52, and Dr. John Hickam, one of our most distinguished heart specialists and professor of medicine at the University of Indiana, died at the age of 55 of a stroke due to rupture of an aneurysm.

Taken together, stroke and heart disease are by far the most common or No. 1 cause of death and disability in the United States.

The CHAIRMAN. I want to express my appreciation for the analysis you have just made. You have cited this as a disease that affects the young as well as the old.

One of those cases was 52 and one was 55. I want to say from my point of view they were young.

Dr. MEYER. Right, sir, the most productive years of life.

The CHAIRMAN. Those are some of the most productive years of a man's life, in the fifties.

Dr. MEYER. Right.

The CHAIRMAN. I have never had a more constructive output of work in my life than in that decade. I know what you say is correct from actual experience.

Dr. MEYER. Stroke affects young and old alike but the highest incidence of a stroke is in the decade of the greatest productivity; namely, the late fifties and sixties.

Among the great politicians who have died of stroke were President Roosevelt, Winston Churchill, Joseph Stalin—and they all had strokes while in office—and both President Eisenhower and Chancellor Adenauer suffered from strokes while in office.

Much has been learned from research already that can be widely applied and taught in the prevention and treatment of stroke. This is being done by the regional medical programs.

They have established teaching programs and stroke centers and workshops, and have disseminated this information so that information about prevention and treatment of stroke is at last beginning to come off the production lines. These preventive and therapeutic advances include medical and surgical approaches.

There is also a need for further studies such as the Framingham study, for example.

I will cite the study of the cholesterol lowering drug for the use in stroke. These types of programs are quite obviously ones which should be widely disseminated.

Mr. Chairman, in my opinion, your committee has a more serious responsibility than in any previous year concerning appropriations for the regional medical programs.

There is the responsibility to the taxpayers and citizens of this country to continue these important programs that have been initiated and not to strangle them during their growth period by lack of funds.

If they are not supported, the quality as well as the actual delivery of medical care in the United States will deteriorate for years to come.

I would also support training and research in these special categorical areas as part of the work of this network of centers across the United States.

Here I would like to add another comment. I have been thinking in the past few days about this presentation. My chairman, an elected representative of the taxpayers and the people of the United States, it should be emphasized again how important is the work that you and your committee are doing.

I really think, at this point in time, delivery of medical care represents a disaster area. I think it is that bad. We have a tremendous shortage of doctors in this country, a tremendous shortage of the delivery of health care.

I predict the taxpayers are going to elect men to represent them in the next few years who are going to amend the poor situation in terms of delivery of health care and the shortage of doctors.

I think this is a fundamental problem that we have to face in the next few years.

The CHAIRMAN. Doctor, I agree with you. I came to the Senate after having taught school in rural schools and briefly in the University of Texas Law School, as well as other experiences on the fringe of education.

My chief interest was education. I was here about 9 months when I got on the Health Subcommittee and the Education Subcommittee. I have been on each for 12 years.

Last year, when I became chairman of the full committee, due to the unfortunate retirement of Senator Lister Hill, who had great seniority and voice in the Appropriation Committee, after 12 years I had reached the conclusion you just expressed, that health care was a disaster area in America.

About the time I came on the committee, the Russians launched Sputnik 1. Many people throught education was a disaster area. The Russians were ahead of us in science and engineering. So we passed the National Defense Education Act of 1958 which started the whole vast complex of educational bills.

At that time, there were 2¾ million students in college in America. We set a goal of trying to double the opportunities so that twice as many students could go to college in 10 years. We have raised that from 1958 to the present, not quite 12 years, to where the number of students in colleges in America have increased to 8 million. Not all are taking the right courses, perhaps, to fill the great needs of America, and certainly there are not enough in medicine and the allied health professions. There are great shortages there.

We have closed the gap in certain educational lines, however.

When the option came last year, I gave up what I really had worked on mostly for 12 years, and decided the health field was a disaster area which needed greatest attention of all the domestic needs in America.

I put the domestic need ahead of military ventures in Southeast Asia where we have squandered $100 billion in 9 years.

I think it is time we did something to improve the quality of life here.

Dr. MEYER. Senator, thank you. I would say you are continuing the great work of Senator Hill because the training and development of doctors and specialists and competent people in the field of medicine is basically an educational problem, as you very well know.

The CHAIRMAN. You have to educate the people to support these programs.

Dr. MEYER. That is another area for education.

The CHAIRMAN. And educate government to support them. The people may be ahead of the government.

Dr. MEYER. Right, sir. I was going to add something that you know very well, Senator, which perhaps should be on the record.

When your committee members and the rest of the Senate and House are considering other things that come before them, let me remind them that without good health nothing is any good.

If you don't have good health, you can't enjoy anything.

The CHAIRMAN. I agree with you. It is unfortunate that the one appropriation bill vetoed was the one where we put in $9 million and

$10 million and $11 million more to study heart disease, cancer, and stroke.

Dr. MEYER. I think that was a regrettable mistake.

We miss Senator Lister Hill, but, personally, I would like to express gratitude for the leadership of men like you and Senator Magnuson.

Now I would like to tell you, in a few words, about exciting advances in diagnosis and treatment of stroke that we already have available.

It has been shown by scientific proof that surgical reconstruction of the carotid arteries in the neck benefits certain patients who have repeated little strokes and prevents them from having catastrophic stroke or even death from them.

In other words, it has been scientifically proven by taking two groups of patients who are comparable with warning symptoms of stroke and submitting one group to surgery and the other to medical treatment, that the ones that get surgery do better in terms of survival or in terms of mortality rate, and also in terms of quality of survival.

That is, they not only live longer and fewer of them die, but they live a better type of life in terms of disability.

The warning symptoms of stroke have been defined and they consist, for example, of transient impairment or loss of speech, transient attacks of paralysis of one side, brief attacks of numbness of part of the body, and so forth.

Certain types of medical treatment have also shown to be beneficial. These include such things as the use of low molecular weight Dextran—which is a form of blood substitute, but it prevents blood clotting, sludging and so forth, and probably dissolves clots, too, and reduces brain swelling—in the acute stroke and the use of anticoagulants and other drugs to prevent strokes.

There is also a good deal of evidence that treating high blood pressure will prevent or ameliorate strokes. Patients with high blood pressure, if they are not treated, will problably go on to suffer from a cerebral hemorrhage if the blood pressure becomes high enough.

This is generally not known among physicians and they don't treat blood pressure until it becomes symptomatic.

There is a good deal of information that other facts, such as weight control, prudent diet, and control of smoking prevent the incidence of stroke.

This type of information is being rapidly disseminated across the country by postgraduate educational programs, workshops, and lectures.

However, in this modern day and age, it is essential to have centers scattered in a network across the country to provide the type of expert diagnosis, surgical, and medical treatment that I have described and I hope you and your committee will see that the regional medical programs supported by this bill, S. 3355, continue to carry out this important work.

I would be pleased to answer any questions you and your committee may have, particularly related to the area of stroke.

The CHAIRMAN. Doctor, we appreciate your testimony very much. I must leave for 30 or 40 minutes to testify before another committee

that I am not a member of. Senator Eagleton, a member of this subcommittee from Missouri, who has been one of the most energetic and determined and productive members of this committee, very much interested in health and our strong right arm on all health measures, has left another committee to come here to preside until I can return.

Senator EAGLETON (presiding pro tempore). Thank you, Dr. Meyer, we appreciate your presentation.

Dr. MEYER. Thank you.

Senator EAGLETON. Our next witness is Congressman Edward G. Biester, Jr., of Pennsylvania.

STATEMENT OF HON. EDWARD G. BIESTER, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. BIESTER. Thank you, Mr. Chairman.

Mr. Chairman, I will not tax the time of the committee with a recitation of my prepared statement. I do not ask leave to submit it, and to tell the chairman that I am here not out of expertise but one of concern in the special field of kidney problems in our country, and here to express, on behalf of over 100 Members of the House of Representatives the interest that we have in seeing that something is done this year with respect to the catastrophic circumstances that affect both the potential patients and the families of persons afflicted with kidney disease.

I think that any legislative approach to the kidney problem must involve a mix of better preventive techniques, deeper research, and more equitable treatment facilities.

Under those circumstances, and because of the situation which obtains today in the field of kidney treatment, which I am sure the Chair is quite familiar with, I am here simply to underline that concern on the part of those members and their willingness to participate as we can in seeing a resolution of that problem.

I have enclosed with my statement a list of the Members of the House of Representatives who have cosponsored our bill. That bill is a companion bill to the bill of the senior Senator from New York. If one were to go through that list, one would find that the support is not only bipartison, but spreads across the spectrum of political philosophy in the House.

I would be pleased to try to answer any questions the chairman has, but I would admonish him that I am here more out of concern than expertise.

(The prepared statement of Congressman Biester follows:)

PREPARED STATEMENT BY CONGRESSMAN EDWARD G. BIESTER, JR., A U.S. REPRESENTATIVE FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I want to thank the members of the Subcommittee for the opportunity to testify today.

One of the major problems facing medicine and public health is the lack of trained personnel, available facilities, research and equipment for the diagnosis evaluation, treatment and prevention of kidney disease. No parallel situation exists in medicine; that is a situation in which successful techniques have been developed for the diagnosis and prevention of diseases which would save lives, and yet at the same time, people continue to die from kidney disease because of the lack of facilities to supply those techniques for diagnosis and treatment.

Senator Javits and many other Senators have introduced legislation entitled "The National Kidney Disease Act" which would authorize funds for five years to support cooperative arrangements among medical schools, research institutions and other institutions and agencies to develop and activate larger capacity to prevent and control kidney disease. Over 110 members of the House of Representatives, including myself, (see attached list) have introduced identical legislation.

Physicians report that 10,000 of the kidney disease patients who die each year are considered medically to be good candidates for artificial kidney machine treatment and kidney transplantation. An additional 10,000 patients would benefit from such treatment. Only 3,000 patients have received artificial kidney machine therapy since 1960, including the 500 new patients treated in the past year. Many patients whose lives might be maintained for a significant number of years are now dying because treatment is not available. In spite of the fact that improvements in both dialysis and transplantation technology are needed, I believe, as do many experts (and I am not an expert), that these two forms of therapy are sufficiently well advanced to warrant launching a national program to provide such treatment of those medically suitable patients for whom it is not available today.

Dialysis and transplantation are both extremely expensive and many individuals whose lives depend upon receiving one of these methods of treatment simply are not able to afford it. I don't think we can justify any longer the selection of candidates for treatment on the basis of ability to pay.

A physician should not be forced to choose among his patients as to who shall receive the life-saving treatments, but should be in the position of offering these treatments to all of his patients who might significantly benefit from them and would die without them.

In presenting the 1967 report of the Committee on Chronic Kidney Disease, which had been charged by the Bureau of the Budget with the responsibility of considering all aspects of the problems posed by chronic kidney disease, the committee chairman, Carl Gottschalk, M.D. stated:

> "If a national treatment program is adopted, the Committee wishes to emphasize that it must be a continuing program that has as its objective the provision of these treatment modalities at the earliest possible date for all who require them. Until treatment capability meets demand, agonizing decisions concerning patient selection are inevitable at both the local and national level."

I believe it is time for Congress to give immediate consideration to legislation providing for a comprehensive approach to kidney disease. I consider this one of the most pressing health problems in the United States, because we can and must take advantage of the discoveries of medical research to provide the proven life-saving treatment to the sufferers of kidney disease. Failure to take this step would be a demonstration of a cruel performance gap, a gap which lies between our known and proven capability and our inadequate performance.

Senator Javits' bill addresses a matter of human concern no less than the very lives of thousands of American people each year. I urge your favorable consideration.

COSPONSORS OF THE NATIONAL KIDNEY DISEASE ACT OF 1969

1. Biester, Pa.
2. Kuykendall, Tenn.
3. Corman, Calif.
4. Hansen, Idaho
5. Adams, Wash.
6. Brotzman, Colo.
7. Adair, Ind.
8. Addabbo, N.Y.
9. Anderson, Calif.
10. Anderson, Ill.
11. Andrews, Ala.
12. Andrews, N.D.
13. Annunzio, Ill.
14. Ashley, Ohio
15. Beall, Md.
16. Biaggi, N.Y.
17. Blanton, Tenn.
18. Blackburn, Ga.
19. Boggs, La.
20. Boland, Mass.
21. Brademas, Ind.
22. Brasco, N.Y.
23. Bray, Ind.
24. Brown, Calif.
25. Buchanan, Ala.
26. Burton, Calif.
27. Button, N.Y.
28. Carter, Ky.
29. Chisholm, N.Y.
30. Cleveland, N.H.
31. Corbett, Pa.
32. Coughlin, Pa.
33. Cunningham, Nebr.
34. Daniels, N.J.
35. Dellenback, Oreg.
36. Dent, Pa.
37. Derwinski, Ill.
38. Donohue, Mass.
39. Downing, Va.
40. Dulski, N.Y.
41. Edwards, Calif.
42. Eilberg, Pa.
43. Esch, Mich.
44. Fish, N.Y.
45. Friedel, Md.
46. Fulton, Pa.
47. Fulton, Tenn.
48. Gallagher, N.J.
49. Gude, Md.
50. Hastings, N.Y.
51. Hathaway, Maine
52. Hawkins, Calif.
53. Hays, Ohio.
54. Heckler, Mass.
55. Hammerschmidt, Ark.
56. Helstoski, N.J.
57. Hogan, Md.
58. Horton, N.Y.
59. Hungate, Mo.
60. Hunt, N.J.
61. Kee, W. Va.
62. Keith, Mass.
63. King, N.Y.
64. Leggett, Calif.
65. Lloyd, Utah
66. McCarthy, N.Y.
67. McCloskey, Calif.
68. McDade, Pa.
69. McKneally, N.Y.
70. Matsunaga, Hawaii
71. Mayne, Iowa
72. Mink, Hawaii
73. Moorhead, Pa.
74. Morgan, Pa.
75. Morse, Mass.
76. Murphy, N.Y.
77. Olsen, Mont.
78. Patten, N.J.
79. Pelly, Wash.
80. Pepper, Fla.
81. Pettis, Calif.
82. Philbin, Mass.
83. Podell, N.Y.
84. Powell, N.Y.
85. Price, Ill.
86. Railsback, Ill.
87. Rees, Calif.
88. Riegle, Mich.
89. Rhodes, Ariz.
90. Robison, N.Y.
91. Roe, N.J.
92. Rosenthal, N.Y.
93. Ruppe, Mich.
94. Ryan, N.Y.
95. Scheuer, N.Y.
96. Shriver, Ga.
97. Stratton, N.Y.
98. Taft, Ohio
99. Thompson, Ga.
100. Tiernan, R.I.
101. Tunney, Calif.
102. Vigorito, Pa.
103. Waldie, Calif.
104. Weicker, Conn.
105. Whalley, Pa.
106. Whitehurst, Va.
107. Williams, Pa.
108. Wright, Texas.
109. Kyros, Maine
110. Yates, Ill.
111. Yatron, Pa.

Senator EAGLETON. Thank you very much, Congressman, for coming before the committee today.

Mr. BIESTER. Thank you.

Senator EAGLETON. The next witness is Dr. George Schreiner, professor of medicine, Georgetown University, and president, National Kidney Foundation.

STATEMENT OF GEORGE E. SCHREINER, M.D., PROFESSOR OF MEDICINE, GEORGETOWN UNIVERSITY, WASHINGTON, D.C., AND PRESIDENT, NATIONAL KIDNEY FOUNDATION

Dr. SCHREINER. Thank you very much, Senator. I appreciate the invitation to be here.

I can speak for the National Kidney Foundation and also as president-elect of the American Academy of Urologists, a national association in this field.

Our statement has been reviewed and approved by all the urological-surgical societies in the United States, which are in complete conformity with our testimony.

I would ask permission to insert my statement into the record.

I also have a statement from Dr. Carl W. Gottschalk, who has the chairman of the committee on chronic disease, called by the Bureau of the Budget.

Incidentally, to my knowledge, that was the first time that the Bureau of the Budget, in the history of the United States, ever addressed itself to a medical question.

I think this is some index of the economic impact of kidney disease in the United States.

Dr. Gottschalk was chairman of that committee and he has prepared a statement.

If agreeable to you, I would like to insert that into the record.

Senator EAGLETON. Both your statement, Doctor, and the statement of Dr. Gottschalk will be made a part of the record.

(The prepared statement of Dr. Schreiner and Dr. Gottschalk follow:)

PREPARED STATEMENT OF GEORGE E. SCHREINER, M.D., PRESIDENT, NATIONAL KIDNEY FOUNDATION

Mr. Chairman, thank you very much for the opportunity to present testimony before your Committee. I am President of the National Kidney Foundation and appear here today as the representative of the Foundation's lay and professional leadership throughout the United States. We wish to make known our very strong support for enactment of Senate Bill S. 3355. I wish to address myself particularly to the kidney disease provisions contained in this bill. My colleague and friend, Dr. Samuel Kountz appeared before this Committee yesterday and addressed himself primarily to the treatment of kidney disease by transplantation. I wish to discuss some other aspects of kidney disease.

The regionalization of health services across the country such as is being developed through the Regional Medical Program Service, offers the most appropriate channel through which to attack kidney disease problems. The incorporation of kidney disease as a named concern of the Regional Medical Programs will be a major stimulus to improving our capacity to improve medical services to the people of this country. At the same time, the multi-discipline, regional approach of the Regional Medical Programs Service is the best way to assure efficient use of men, money and facilities to attack the interrelated problems of heart disease, cancer, stroke and kidney disease.

The need for a broad, organized attack on kidney disease has been repeatedly emphasized. Diseases of the urinary tract attack 8,000,000 Americans each year. Approximately 56,000 of these individuals progress to terminal uremia each year and die. Because kidney diseases are likely to cause death of patients in their most productive years, they make a greater economic impact than basic data suggests. They cost this country an estimated $1.4 billion annually in lost future income.

Mr. Chairman, I reconize that this country is facing serious economic problems today. The Administration is effectuating hard decisions, reducing or suspending many important programs to curb Federal expenditures in a period of inflation. But, Mr. Chairman, we are not true to our trust as physicians if we permit the untimely deaths of many Americans to continue in the name of anti-inflation. The fact of the matter is, we are not doing the job. Over the past five years, we have provided kidney dialysis and transplantation to less than ten percent of the extimated 40,000 medically good candidates for these therapies. Only 3,000 patients have received kidney machine treatment since 1960, including 500 new patients accepted last year. Only about 2,200 patients have received kidney grafts, including about 500 performed last year. This means that last year, we permitted 90 percent of the medically good candidates for dialysis and transplan-

tation to die. This rate of costly deaths will continue this year, and in future years unless aggressive action is taken. Moreover, Mr. Chairman, the figures I have just cited do not take into account the thousands of other terminal kidney disease patients whose cases are more complex, but whose medical condition could be improved by dialysis, or transplantation.

There is an aspect about this problem which I believe needs immediate clarification. In the early days of the past decade, when we were developing our skill in hemodialysis, and pioneering in kidney transplantation, large sums were cited as the estimated cost of providing these therapies. The Gottschalk Report in 1967, for instance, estimated a figure approaching a billion dollars to provide dialysis therapy to all the best medical candidates. It appears that two serious errors were made in those years which have continued to paralyze action. First, we neglected to build into the estimates the cost reductions which could be achieved with the treatment of larger numbers of patients, and alternative modes of treatment. Second, it was apparently assumed that the Federal Government would be called upon to bear all of the high costs.

Where large numbers of patients are dialyzed, or transplanted, Mr. Chairman, the costs are being brought down very significantly today. For instance, where early kidney transplants cost upwards of $30,000, they are now down in several localities to $7,000 to $15,000, depending upon the experience gained by the transplanting institution, and patient complications. The differences in cost between home dialysis by the patient, and the provision of this therapy in the hospital setting have been frequently cited, home dialysis running less than one-third that of the lowest cost in the hospital setting.

With respect to my second point, physicians and institutions who have pioneered dialysis and transplantation are finding a variety of funding sources for their current activities, such as health insurance, state funds, Medicare and others. The bill can be shared, Mr. Chairman, and should be shared in the same manner that other high-cost, or long-term illnesses are covered. A key role can be performed by the Federal Government in helping to organize the utilization of available patient support.

We are particularly gratified to see specific funds earmarked for kidney disase within this Regional Medical Programs Service legislation. It is our anticipation that while no funds are specified for kidney disease during 1972–1975, the programs developed in 1971 will provide means for the determination of reasonable funding of kidney disease programs in subsequent years. Mr. Chairman, the kidney disease problem cannot be solved in one year, or two, or even three years. It solution will come through steady attack across a number of fronts which will permit the medical community to develop and employ increasing and sophistication in effective prevention and control of kidney disease.

We can make immediate impact, particularly in the framework of the Regional Medical Programs Service by accelerating integrated programs for renal dialysis and transplantation.

1. Home dialysis training programs should be developed in conjunction with all major transplant centers, and a dialysis patient pool of at least 100 patients could be generated to support each transplantation program. In addition, a limited number of dialysis beds would have to be available to support transplant patients during the immediate pre- and post-operative periods.

2. Transplantation potential should be added to the existing nucleus of home training and incenter dialysis programs now established throughout the country. The distinct advantage of this possibility is that dialysis pools would already be in existence and an annual transplantation capability of 20–40 patients probably could be realized in each center within 1 to 3 yers.

3. All funds allocated for the purposes described in items 1–2 should be distributed through awards which provide for the establishment of physical facilities, purchase of equipment, training of staff, and support of key personnel for a limited time period (e.g., 3 to 5 years).

A portion of kidney funds must be devoted to definition of the number of specialty people requiring training in renal disease, and the nature and level of courses required. While a larger number of physicians and nurses are needed in kidney disease treatment, and management, there is a unique opportunity in kidney dialysis to delegate the performance of on-going therapy to highly trained technicians.

Mr. Chairman, we must not forget that the ultimate soution to kidney disease will be its prevention. Major areas in which work should be pursued include:

1. Development of pilot studies with the control of hospital-acquired infections.

2. Development of improved screening procedures for the detection of early infectious renal disease.

3. Development of implementation of improved diagnostic procedures for the detailed evaluation of urinary tract diseases.

Mr. Chairman, with your consent I would like to include in the record of these hearings a statement by Dr. Carl Gottschalk, Professor of Medicine at the University of North Carolina, School of Medicine, in support of S. 3355. In addition, I wish to call to the Committee's attention the endorsement of the legislation to extend the Regional Medical Program to include Kidney Disease by the Scientific Advisory Board of the National Kidney Foundation.

"The Scientific Advisory Board of the National Kidney Foundation recommends that Federal funds be directed toward the support of existing nephrology centers with special competence in the areas defined below, or the establishment of comprehensive regional nephrology programs where such do not exist. The primary purpose of these programs would be to extend renal disease control methods to the community level through the education of an increased number of medical and paramedical personnel. Specific needs for any given region would be determined jointly by the training center and community physicians involved.

"Within the limitations of available funds, such programs could be established. Proposals would be requested on a competitive basis with regional need and the comprehensiveness of the proposed plan to meet that need as the major considerations in selection of recipients.

"A special committee composed of acknowledged national leaders in the field should serve in a consultant capacity to the Regional Medical Program Services in review of applications and the formulation or plans. Although the specific needs of each individual region will vary, it is anticipated that the followng general types of activities will be included:

"1. Post-graduate and short-term training for physicians, nurses, technicians and other supportive personnel.

"2. Development of basic treatment facilities where they do not already exist.

"3. Initiation of early detection programs, including community renal clinics and screening studies.

"4. Establishment of continuing professional education programs in interdisciplinary training.

"5. Development of specific diagnostic and therapeutic services which because of their complexity must be located at the region's major teaching center(s).

"6. Provision of administrative personnel whose responsibility will be to coordinate regional health service agencies and programs.

"Although the needs for each region will vary considerably, the major categories of expenditure would include support of key personnel, renovation and/or construction of facilities in the academic center and affiliated community hospitals, and training awards. Direct support of routine patient care is to be excluded."

The above mentioned statement is supported by the American Urological Association, the American Society of Genito-Urinary Surgeons, the Clinical Society of Genito-Urinary Surgeons and the Society of University Urologists. This means quite simply that the proposition is endorsed by all the leaders of medical societies having to do with both the study and treatment of kidney and other diseases of the urinary tract both medical and surgical. For the first time both the medical and surgical groups interested in kidney diseases and those of other parts of the urinary tract, including prostate and bladder, have united in support of the bill proposed by Senator Yarborough.

PREPARED STATEMENT OF DR. CARL W. GOTTSCHALK, PAST CHAIRMAN OF THE COMMITTEE ON CHRONIC DISEASE

Mr. Chairman, I am very grateful for the opportunity to testify before this Committee. I have been interested and involved in kidney disease activities for some years, and it is a pleasure to speak in support of the opportunities for real progress which are embodied in the Bill, S. 3355.

Some years ago, I was honored to Chair the "Committee on Chronic Kidney Disease," called by Charles Schultze, who was then Director of the Bureau of the Budget. I believe I can best make my point, Mr. Chairman, by citing the first conclusion of that Committee in 1967.

"1. Although by no means optimally developed, both chronic hemodialysis and renal homotransplantation are capable of prolonging life. Yet many patients whose lives might be maintained for a significant number of years are now dying because these treatment forms are not generally available. Approximately one out of five patients dying from chronic uremia are medically suitable candidates for treatment by dialysis and transplantation. Of the estimated 7,000 new patients in fiscal year 1968 with chronic uremia who will be medically suitable, treatment by transplantation will be available for approximately 450, and by chronic dialysis for approximately 550. In addition, approximately 750 patients from previous years will be maintained on chronic dialysis. Even though improvements in both dialysis and transplantation technology are needed and undoubtedly will be achieved in the future, *these two forms of therapy are sufficiently well advanced today to warrant launching a national program* intended to provide such treatment for those medically suitable patients for whom it is not available today."

Mr. Chairman, that statement is as true today, as it was in 1967, and yet we still do not have an organized national program to provide capability to care for these dying patients.

I see real opportunity for organized, effective action on the kidney disease problem through the regionalization concept pursued by the Regional Medical Programs Service. In North Carolina, we have been getting some real experience in this directly in the field of kidney disease. We have three hospitals which are providing chronic kidney dialysis, two centers which are performing kidney transplantations, and two laboratories which perform tissue typing, and which are participating in scheduled multi-State meetings to compare notes on tissue typing techniques and transplantation experiences. Our State Board of Health, in Raleigh, is just now completing a pilot plan, funded by the Kidney Disease Control Program of the Regional Medical Programs Service, for a State-wide hemodialysis program. The development of this plan has resulted in outstanding success in getting government, professional and lay people to cooperate in pulling together organization for the ultimate solution to my State's kidney disease problems. When we can proceed on this plan, it will be closely coordinated with the North Carolina Regional Medical Program, and the comprehensible health planning people.

Mr. Chairman, I enthusiastically endorse S. 3355 a way to get this country moving on its kidney disease problems.

Dr. SCHREINER. There are a few points which I think deserve emphasis. It may not be known to everyone that this field of disease is a relatively new area for medicine. It lacks many of the formal attributes of the older subspecialities. That is, it does not have board examinations for certification and tight educational programs that are restricted.

It does not have examination or licensure and does not have an institute.

So it has come onto the medical scene without much of the supporting structure that other specialties of medicine have had.

The kidney foundation is a relatively small organization. It has simply happened partially as a result of research developments that this field has exploded both in diagnostic capabilities and in treatment capabilities, so that we have not one but two definitive methods of treatment for end-stage kidney disease, one employing the artificial kidney and the other employing transplantation of kidney, which has been the most successful form of organ transplantation of any of the organs that have been tried to date.

The area of transplantation was covered yesterday by Dr. Kountz in his testimony, so I will not duplicate that.

I would like to point out the importance of developmental research on newer diagnostic techniques. This area has become so important. It is the leading cause of absenteeism in the women work force and about the third or fourth leading cause of absenteeism among males

in the work force. So it has an economic impact even greater or as great as the impact of the end-stage kidney disease.

Dr. Farber indicated, of course, that kidneys are also a site for the development of a particular kind of cancer in young children.

We have some of these techniques that have come off the drawing board. I could cite a few of them. We have found, for example, that it is possible, by a relatively simple method that does not even require going to an operating room, to remove a piece of kidney for diagnostic purposes. This has been done now for a number of years.

These specimens, by and large, are examined only with standard pathologic techniques. Yet, we have discovered two other ways of examining them, one with electron microscopy, and the other with the use of fluorescent stain. This involves taking proteins that deposit on tissues with a material that fluoresces in ultraviolet light and examining this in a very special way. This is quite expensive.

An examination of a single specimen from a single individual would cost something like $300. And yet, it provides diagnostic information which is not available by any other method.

Because of its expense and because of the limitations on the people, the trained people, to do this, these techniques simply are not being applied, so that a number of patients, in spite of going to the finest hospitals, are really not getting the ultimate in modern diagnostic techniques that we know about from the scientific side.

It will never be possible, probably, for every hospital to have all of these techniques available because the equipment is just too expensive and too cumbersome, and there aren't the people trained to operate them.

So we can't have an electron microscopist in every community hospital such as we have a pathologist.

These kinds of techniques lend themselves to regionalization perhaps better than any other field of medicine because they involve new expertise, new equipment, new space design, new kinds of construction, and they are not in competition, really, with anything that currently exists, that is available. They are additive to what exists in our health delivery scheme.

I think that the entire field is almost tailor-made for the regional concept. In fact, we feel it could be a kind of a design prototype. That is, if it were worked out in this area where we already have scientific developments, the lessons to be learned, I think, would be applicable to other fields of medicine as well.

Dr. Kountz mentioned that on the west coast they have a computer-based transplantation tissue typing mechanism. We have 12 universities now that have done this on a volunteer basis, here in the mid-Atlantic area, Johns Hopkins and Georgetown, down to Atlanta.

Just in our own hospital since Christmas, we have done a kidney transplant from Atlanta, from a donor who died in an automobile accident in Atlanta, which was transported by commercial jet to Washington National Airport.

We have also transplanted kidneys from Johns Hopkins, Richmond, and Charlottesville.

We employed commercial air transportation and private air transportation from Charlottesville. The State police brought the one over from Baltimore.

So we are trying out new ways or organizing the transportation aspects of this, the administrative aspects of it, the scientific aspects of it, and the delivery aspects of it all at the same time.

This is a kind of pilot, developmental research. It isn't the basic research that goes on at the NIH. It is the developmental research which is necessary if these things are going to go from the bench to the bedside.

There is an intermediate period, a gray zone. We have no structure at the present time to really work in this kind of research.

The basic scientists, understandably, doesn't have the background. He does not want to concern himself with this aspect of research. The deliverer of health care, the insurance companies, medicaid and medicare, cannot accept these because they haven't been totally developed for service use.

So there is a gray zone in between which, in the industry, is called the pilot plant project.

We don't have a real mechanism in this country for going through that gray zone. This is the area that we feel the regional medical program, by emphasizing training, delevelopmental research, pilot projects, can really serve a basic need which simply isn't being met today.

The point I would also like to make about construction is I am aware that there has been some opposition to this. I simply cannot see how you can go into new programs without having authorization for construction. There are three basic reasons for this.

One is that there is no space left for remodeling in most hospitals in the United States, particularly university hospitals. Many of them are under constructed.

Second, the application of these techniques requires often specialized forms of facilities construction.

Third, it is actually cheaper to construct a specialized facility that is designed to do the job well than it is to misuse existing hospital facilities for this purpose.

So you will find a great deal of ingenuity involved in the areas that have been assigned to kidney disease in the various hospitals around the country.

Dr. Scribner, who pioneered in this field, first set up his unit in the basement of a nursing home. There are other areas where they remodeled hospitals that were abandoned and declared unfit for use.

In our own university, we spent 5 years trying to get our hospital administrator to devote a small area that we could redesign for a new kind of home training program.

It wasn't until just a few weeks ago when we built a child development center and the brick wall blocked the windows to the hospital rooms and made them unfit for patient use, that they gave us this area.

The point I am trying to make is that the space is so tight that it is really impractical to talk about instituting new programs without providing the capability for some type of innovative construction.

It shouldn't be an eventual construction. It should be innovative. This is absolutely necessary. Otherwise, the hopsital administrators, who are beset with space problems now, simply won't take on these programs. There is no way for them to do it. It is easier to say no than to face the impossible space situation.

A few weeks ago I was in your area to dedicate a new dialysis unit in a hospital. For example, the State of Missouri voted some money for the treatment of kidney disease, but there was no construction available. They simply couldn't do it for several years on the scale that was necessary in that hospital, Barnes Hospital, one of the finest in the United States.

The Kidney Foundation, I am happy to say, was helpful in contacting a private individual, a New York industrialist with roots in St. Louis, who gave Barnes Hospital the money to construct this unit.

There wouldn't be any dialysis treatment in St. Louis if it wasn't for this kind of personal gift, despite the fact that there was State money available for the support of the patients. There was not money for the facilities.

So I feel very strongly that the construction features of this bill should remain in and should be intact, and should stress innovative construction.

I will be happy to answer any questions, Senator Eagleton.

Senator EAGLETON. I saw the kidney unit they have at the Kansas City Hospital complex. The facilities there, to me, didn't seem to be terribly elaborate in terms of construction. The machines are very, very expensive, I understand.

I am a layman so you have to bear with me. What is the enormous expense in a construction that is involved?

Dr. SCHREINER. It is not really enormous. It is, rather, that it should be appropriate. In other words, if you are going to, for example, set up a home training program, you should have an area where the patient can, in his final stages of his training, be by himself, be alone.

This type of area doesn't exist in most hospitals. It could easily be put, for example, in an extended care wing attached to a hospital. It doesn't require the $100 a square foot type of construction, as you pointed out. Therefore, the hospital administrator doesn't want to devote a hospital bed to put that kind of a unit in. It is not economical to do that.

What we need, really, is the ability to, in some cases, build a cheaper form of construction which doesn't take away from the existing very expensive hospital construction.

So many of the Government programs have only had money for the remodeling of existing facilities, and all those nooks and crannies have been used up.

We are now in the situation where we have to take out beds in order to put in a training unit, and this is very uneconomical. It is deleterious to the existing hospital and it is also not the properly designed space.

For a transplantation, of course, the care of transplant patients, that is more of the intensive care type of facilities that are needed.

One should be able, for example, to have isolation from bacterial and fungus infection during the time that the patients are on suppressive drugs.

A chronic in-center dialysis facility, a home training facility and a transplant facility all should be designed differently. Each has an optimum size for the proper use of the personnel.

When you are just simply carving this out of a hospital room or two rooms or four rooms, depending on how generous your hospital

administrator is, you are not fully employing the people or the space. You are simply making do with a bad situation.

A nurse, for example, might be appropriate for a dialysis nurse or technician, to service 10 beds. The hospital administrator might say, "I can only give four for this purpose." You can't have four-tenths of a nurse, so you are wasting manpower by having inappropriate use of the facilities.

Senator EAGLETON. What kind of a facility is at Barnes?

Dr. SCHREINER. That was opened about 2 weeks ago. It is well designed. It is about eight beds and it has the special laboratories and so forth all integrated in one single unit.

Senator EAGLETON. Was it a new wing added on?

Dr. SCHREINER. I think it was some type of a connection between the old hospital and the new building that is being built. I did not see the space before it was constructed, but it is a very well designed unit.

Senator EAGLETON. It is my understanding that there are 55 regions throughout the country.

Dr. SCHREINER. In the regional act, yes.

Senator EAGLETON. And there are a certain number of them that are in operation. When we get to the point when all 55 are in being and hopefully functioning at the optimum level, as you view it, would there be within each region just one medical complex, whether it be here at Georgetown, at Barnes, or at the hospital in Kansas City, that would have facilities of the type we have discussed, one and one only, and everybody else would depend on that medical complex?

Dr. SCHREINER. No, I don't think they could do the job. I think there will have to be a center integrated unit where the training and research can go on side by side. Then certain aspects of this could be done in satellite units in community hospitals once you had the individual trained.

In fact, we are even sending patients home now to do this, either having the spouse or a member of the family assist in the dialysis on the few occasions we have been able to get people to do it themselves with more expensive kinds of treatment.

At Jefferson University in Philadelphia, they teach the full schedule of dialysis themselves.

Far from subtracting or putting a strain on the manpower pool, they actually added to the medical manpower pool by having health personnel keeping alive those who would otherwise be dead.

It is theoretically possible in this field to train individuals who do not have a professional background. If I may take the time, I might point out, as you well know, in medicine it is very difficult to get by the vested interests of the various people in the health professions.

A nurse who has been trained with high standards doesn't like to see another individual take over part of her duties who is not nearly so well trained. One of the beauties of kidney disease is that nobody is trained, so that we have to train either the nurse or some other individual and, therefore, one can actually develop without friction new forms of health personnel.

My dialysis technician at Georgetown is a disabled electronics sergeant from the Air Force. Dr. Scribner's chief technician was a filling station operator. So we have taken people out of the medical manpower field and we have put them in. I think this is a concept which the

Health Manpower Commission didn't understand, at least when I testified before them. All they could do was take the numbers of people, the number of nurses, that were suggested by the Veterans' Administration, and came up with this horrible concept that it couldn't be done because we didn't have enough people. But this is an area in which we can indulge in innovative training; we can go around the fixed positions of people simply because it is new.

So it is a wonderful way, really, to pioneer new forms of training and education.

Senator EAGLETON. Thank you very much, Doctor. We appreciate your testifying before the committee.

Dr. SCHREINER. Thank you.

Senator EAGLETON. Our next witness is Dr. James Metts, chairman, community cardiovascular council, and director of comprehensive stroke unit, Savannah, Ga.

STATEMENT OF DR. JAMES C. METTS, JR., CHAIRMAN, COMMUNITY CARDIOVASCULAR COUNCIL, AND DIRECTOR, COMPREHENSIVE STROKE UNIT, SAVANNAH, GA.; ACCOMPANIED BY D. BOYD YARLEY, CITY ALDERMAN, SAVANNAH, GA.

Dr. METTS. I am Dr. James C. Metts, Jr. I am a physician in the private practice of internal medicine in Savannah, Ga., and I represent the community of Savannah, Ga., through its community cardiovascular council.

This council is composed of representatives of the citizens of Chatham County, Ga., from all walks of life.

I am accompanied by City Alderman D. Boyd Yarley who represents the city government.

I would like to direct your attention to page 1 of the brochure I have handed out.

It is a fact that heart disease is the No. 1 cause of death in the United States and that stroke is the No. 2 cause of death in the United States.

Our particular interest in this matter, of course, is the historical fact that Savannah, Chatham County, has one of the highest incidences of heart disease and stroke of any county in the United States.

I am here to present certain recommendations and suggestions regarding Senator Yarborough's bill, which is now pending before the Senate.

It is our opinion that this is a very good bill but we feel that certain sections should be clarified.

My testimony relates to the chronic disease section of the regional medical program services. In all sincerity, I am not competent to speak on the whole problem of chronic diseases but must restrict my comments to the problem of heart disease and stroke.

It is well documented that cardiovascular disease (heart attack and stroke) account for more than one-half of the deaths in Georgia, and my county of Chatham has one of the highest incidence rates of heart attack and stroke in the United States.

I submitted a table for the committee that has the latest statistics for 1967 and 1968 for Georgia. This is generally true on a nationwide basis.

(The table referred to follows:)

HEALTH STATISTICS RELEASED FOR 1967–68

Heart disease was responsible for almost one-third of the total deaths in Georgia last year. Over 14,000 died of heart disease while almost 6,000 more died of stroke.

As a cause of death, cancer dropped to third place in 1968. It has been the second most frequent cause in 1967.

The Biostatistics Service of the Georgia Department of Public Health prepared the chart below giving graphic outline of the state's mortality rate.

The serious outbreak of influenza in the late part of 1968 was responsible for pushing the death rate in this category to a new high, almost 500 more than the previous year, or an increase of more than 30%.

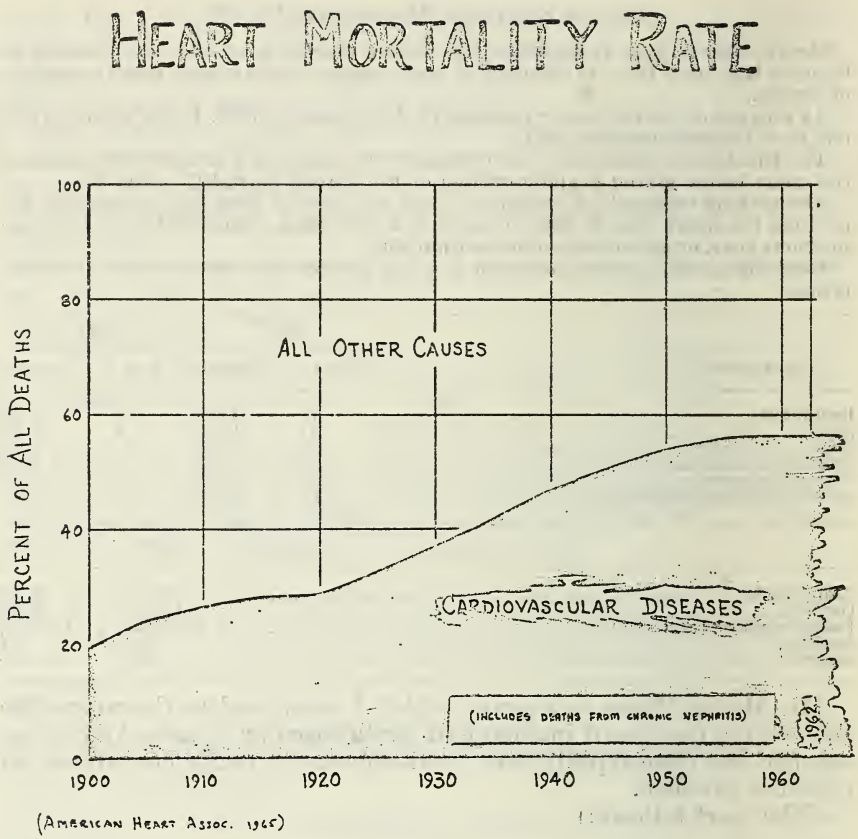
Homicides and suicides increased at a far greater rate than did the net population.

Cause of death	1968		1967	
	Rank	Number	Rank	Number
Heart disease	1	14,155	1	12,946
Stroke	2	5,828	3	5,494
Cancer	3	5,534	2	5,519
Influenza and pneumonia	4	2,022	5	1,546
Motor vehicle accidents	5	1,730	4	1,553
Accidents (other than motor vehicle)	6	1,464	6	1,377

	1968	1967
Total all deaths	41,331	38,448
Live births	87,322	86,469
Population (estimated as of July 1)	4,568,000	4,509,000
Homicides	700	617
Suicides	497	455

Mr. METTS. There is a graph which I submitted to the committee delineating the rise of incidence of cardiovascular disease. As you can see, this has risen rapidly over the decade and is really now almost an epidemic problem.

(The chart follows:)



Mr. METTS. These diseases are estimated to cost this country between $20 billion to $30 billion annually. We have been able to determine that heart disease and stroke have certain risk factors which can be manipulated and controlled, and in view of the rising number of deaths from cardiovascular disease each year, it is imperative that we attempt to do something about these risk factors at the earliest possible moment, which is now.

Due to budgetary restrictions, the Department of Health, Education, and Welfare is determined to abolish the entire chronic disease section. It is the considered opinion of qualified investigators and observers that this is an extremely poorly planned and ill-advised move.

The implications of abolishing the chronic disease section are grave and numerous. Speaking from my own point of view, HEW's proposed action would mean abolishing the entire heart disease and stroke control program on a nationwide basis.

We have outlined the magnitude of the problem of heart disease and stroke in this country. The heart disease and stroke control program is the only program currently attempting to operate on a community level to modify, here and now, the actual attack rates of heart disease and stroke.

Basic research in universities is well and good, but unless some concrete plans are made to apply this to preventive medicine on a community level, much of this research will be in vain.

Heart disease and stroke have reached epidemic proportions in this country and major intervention must be now. We cannot afford to wait 1, 2, 3, or 10 years to begin work on this problem.

I feel that the regional medical program with its local planning base and the reception it has received from the private section of the health community, has been able to contribute effectively to the progress of medicine in all of the areas in which it is involved. I hope this will continue.

The principle of decentralization and regionalization of government which is reflected in the regional medical program is one in which I strongly believe. I would like to point out with pride that our own Georgia regional medical program is rated as one of the highest in the Nation.

I have occasion to visit your facility at Columbia. That is really an impressive facility.

Senator EAGLETON. Is the State of Georgia one entire region?

Dr. METTS. Yes, sir; I believe so.

The heart disease and stroke control program is a relatively small section of the chronic disease section which falls under the regional medical program services. It is, however, a unique group being composed of a hard-core of career professional epidemiologists, statisticians, biochemistrists, and so forth.

This group provides the invaluable service of making their experience and manpower available to projects such as ours across the country, who need consultations which would otherwise not be available.

Groups such as our group in Savannah need funding, true. But funding is not really the most critical point. We need access to trained epidemiologists, career Public Health people, skilled in these investigations to give us consultations and assistance.

This is what we will lose if the heart disease and stroke control program is permitted to go under. This group of individuals would be disbanded and scattered to the winds and their services will no longer be available to groups such as ours.

Savannah, Ga., has been selected as a location for a pilot study and intervention project because it has the highest rate of cardiovascular disease in the United States.

Should we in Savannah be able to modify our morbidity and mortality from cardiovascular disease, and feel that we will be able to, our program could then be applied to other areas in this country whose citizens suffer from these diseases.

However, Savannah, Ga., is not alone in this effort and there are five other areas in the country—Nassau County, N.Y.; Salt Lake City, Utah; Alameda County, Calif.; Hagerstown, Md.; and Birmingham, Ala.—which are members of a Collaborative Community Stroke Study (CCSS).

These studies are not just in the planning phase but are actually operational and have already begun to yield meaningful results in conserving our most important natural resource: people; in other words, you and me.

As one facet of our interventional study, we have begun operation of a comprehensive stroke unit based at the Candler General Hospital. We conducted a 6 months' baseline study of current stroke care in our community, and this will be used to determine whether or not our stroke unit which began operation January 1, 1970, does in fact improve the level of community care of the stroke patient.

These projects are mentioned to indicate to you that work is actually proceeding in Savannah, Ga., toward an interventional program and that this is not something contemplated in the near or distant future.

We are presently working on the protocol for a feasibility program to be conducted in Chatham County, Ga., in the field of heart and stroke.

Unless funds are earmarked for heart disease and stroke, this program with its unlimited potential, will perish, I cannot stress too strongly that there are no similar interventional programs in the Nation to the best of my knowledge.

The people of Chatham County, Ga., have organized themselves to form a community cardiovascular council with the support of the U.S. Public Health Service and the Georgia regional medical program to take action against one of the greatest health hazards—stroke and heart disease.

This council consists of approximately 40 community leaders who represent city and county government, the five city hospitals, health agencies, the model cities program, Protestant, Roman Catholic and Jewish representatives, educational facilities, and so forth.

The general purpose of this council is an advisory one. Members will attempt to combine the capabilities and physical facilities of the area and develop cooperative arrangements to facilitate successful programs for prevention, detection, diagnosis, treatment, and rehabilitation of cardiovascular disease.

This past December, I testified before Senator Magnuson's subcommittee on Labor-HEW appropriations on this matter, and pointed out that funding projects such as ours was of no real value unless some provision could be made to give us access to manpower and experience in conducting these projects.

Senator Magnuson agreed with us wholeheartedly and was kind enough to express himself in his Senate Report No. 91–610, Calendar No. 607, which I now quote:

> The committee is strongly opposed to the proposal of the Department to make a $4 million reduction in Chronic Disease Control Programs and shift this amount to operational and planning grants to the Regional Medical Programs.
>
> This action would entirely eliminate ongoing activities in five disease categories: Heart disease, respiratory disease, cancer, diabetes and arthritis; and neurological and sensory diseases.
>
> Considering the awesome toll in death and disability which these conditions annually extract from the American people, the committee cannot accede to the elimination of Chronic Disease Control Programs of demonstrated value and, therefore, has added $4 million to maintain these programs at their previous operating level. The committee has clearly earmarked the funds for Chronic Disease Control Programs, so that they cannot be used for any other purpose.

Despite Senator Magnuson's committee's recommendations, HEW has remained hellbent and determined in defiance of all commonsense to abolish the heart disease and stroke control program, while maintaining programs of much less value to this country.

I can only attribute this to a very inferior grade of information and advice which Secretary Robert Finch and Surgeon General Jesse Steinfeld, with whom I have met, are receiving from their subordinates in HEW.

The philosophical and political ramifications of HEW's "stubborn stupidity" are beyond my ken.

I am not politically sophisticated but I was under the impression that the task of an administrative arm of Government is to carry out the wishes of the Congress of the United States.

Since the Congress has expressed itself clearly and specifically on this matter, I cannot understand HEW's refusal to even consider the Senate's opinion.

Gentlemen, we in Savannah signed a contract with the U.S. Government through the U.S. Public Health Service. In this contract a group of private physicians and individuals agreed to provide certain services to our community providing that we received some assistance from the Federal Government.

Incidentally, we agreed to render these services to our community without compensation.

I receive no compensation and neither do the others associated with the council. It is a public service.

This included not only simply funds but also the assignment of full-time personnel who are essential to our project. Despite this contract which we thought was binding upon both parties, the Federal Government has seen fit to withdraw personnel from our project without having even the courtesy to notify the project director that this was being done.

As director, the first that I knew that our personnel were being withdrawn was when my secretary casually mentioned that our social worker had been transferred to New Orleans.

As recently as February 12, our U.S. Public Health Service physician, Dr. Thomas Swift, was urged to apply for a transfer to the Island of Guam. Now I have the responsibility of discharging the terms of this contract which I serve without any compensation except personal satisfaction and I consider it "dirty pool" for the Government to unilaterally terminate its contract and withdraw its personnel without some consideration and renegotiation with me and other responsible individuals. If I must say so, this makes HEW look like a pretty shoddy organization.

They said the reason for terminating this program was to cut down, to save money. Dr. Swift is a 2-year man in Public Health Service. They have to pay him for 2 years.

How are they saving money by taking a physician from Savannah, Ga., which has the highest rate of heart and stroke, when he is in Savannah working on heart and stroke—how does it save money and help the country to send him to the Island of Guam?

I do not understand.

Senator EAGLETON. What was the cost of the full-time personnel with your organization?

Dr. METTS. Dr. Swift is paid directly by the Government. We have had a social worker, a nursing consultant and a full-time physician associated with this particular portion.

These individuals are paid directly through the heart disease and stroke control program.

Senator EAGLETON. What did the social worker do?

Dr. METTS. The social worker? As a portion of our study—well, let me backtrack a minute. Dr. Meyer mentioned that there are certain risk factors that we feel will alter the incidence of heart and stroke applied on a community basis.

This had never been demonstrated and it has been a matter of some controversy. Our project in Savannah had two purposes. The first was to assay the depth of the problem, and to determine the actual level of stroke and heart care in the community.

We were then going to try to intervene on a public health level and try to reduce these risk factors across the board, and then to measure the attack rates before the project and after our project to demonstrate to the satisfaction of other people in this field, what could be done, how effective it was, whether it was economically feasible to apply to other areas of the country.

That was the purpose of the social worker and the nursing consultant, to help assay various levels of practice, to abstract hospital records, to interview various individuals concerned, to assay the magnitude of the problem.

Senator EAGLETON. Is your program the only one of its type in the country?

Dr. METTS. Yes, sir.

In Framingham, that is a 20-year study thus far with a much smaller group of individuals.

In our particular group, this is the first time that we know of that anyone has attempted to go into a community, in the same fashion as syphilis, tuberculosis, and these other diseases which have been so rapidly reduced by communitywide measures—to my knowledge, this is the first time someone has gone in and attempted to do something about cardiovascular diseases.

It is more complex in cardiovascular diseases than in tuberculosis. The question is how can this be done in terms of being economically practical?

It is our view that these programs will more than pay for themselves. An individual who has a stroke—I don't know if you have a relative who had a stroke—is converted from being a productive, self-supporting individual into basically a welfare recipient for the rest of his life.

There are exceptions to this.

But stroke is a very catastrophic illness from which a return to productive existence is almost impossible. For this reason, the only real cure for a stroke is not to have a stroke in the first place.

The only good stroke is a stroke that doesn't happen.

But the cost of a stroke is so great that we feel that for the number of people who could potentially be kept from having strokes, the economic savings would more than pay for any other preventive programs you might have.

HEW's own figures for the estimated cost of heart and stroke to this country each year is between $20 billion and $30 billion.

If you can save only a small percentage of that, you can pay for your preventive program.

I would like to refer to page 175, which is a portion of a letter to the Honorable Jeffry Cohelan from Stanley Olson, director of the regional medical programs.

I underlined a sentence to indicate that HEW is definitely and permanently phasing out the heart disease and stroke control program. That letter is my own addition.

Through their recent actions, it is obvious that HEW is not responsive to the will of the Senate. This being the case, it is essential that this committee, in finalizing Senator Yarborough's excellent legislation, spell out in detail the legislative and administrative structure of the chronic disease program as it specifically relates to the heart and disease and stroke control program, with specific guidelines as to what HEW may or may not do to the heart disease and stroke control program.

I am here talking about the nationwide program for heart disease and stroke.

If you fail to do this, the heart disease and stroke control program on a nationwide basis will be dead the instant Senator Yarborough's bill is passed. This is not speculation. I speak from the hard experience from the last few months and I can document what I say. If you permit HEW to disband the heart disease and stroke control program, you will lose a closely knit nucleus of highly trained and experienced personnel who have been assembled over the years.

In doing so you will also automatically disband a number of projects which have been several years in formation and which are just now reaching the point of being really productive.

The harm being done by the present period of disorganization in these programs will require 3 to 5 years to repair, if, in fact, they are even repairable.

It is not enough to give HEW a general set of guidelines for the conduct of the heart disease and stroke control program. Senator Magnuson, in fact, did this rather well, and even specified certain restrictions on the use of funds, unless they were applied to chronic disease programs and the heart disease and stroke control program.

HEW has, by its actions, indicated that it has not the faintest intentions of abiding by the will of the Senate as expressed in Senator Magnuson's bill.

For this reason, I strongly urge you to give careful consideration to the legislative and administrative structure of the chronic disease program and the heart disease and stroke control program. Unless these are specifically outlined in detail, HEW will continue its headlong rush to "junk" the whole program.

Yesterday, I finally received some official notification from a gentleman named Robert van Hoek, officials terminating this agreement or contract with the people of Savannah.

Senator EAGLETON. That will be made a part of the record.

(The communication referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
February 13, 1970.

JAMES C. METTS, M.D.
Candler General Hospital, Inc.,
Savannah, Ga.

DEAR DR. METTS: This is to inform you that the FY 1971 DHEW budget request for health activities does not provide positions or operating funds for

the Heart Disease and Stroke Control Program of the Division of Chronic Disease Programs, Regional Medical Programs Service.

Therefore it will be required that all personnel currently paid from funds available for Program activities in FY 1970 be reassigned or terminated by June 30, 1970.

In terms of Contract Number HGM–110–69–415 this means that Dr. Swift will be withdrawn from the contract as soon as another suitable Federal position can be found for his continued employment elsewhere, and that the nurse and social worker already reassigned will not be replaced. Our Contracting Officer will be contacting you in the very near future with respect to alternative courses of action which may be explored for continued operation of the constructed project, now scheduled through June 26, 1972.

It should be mentioned that new project officers will be assigned, where necessary, to supervise continuing contracts, and arrangements made for the compilation and analysis of the data generated by the contracts.

We very much regret that this action is necessary, but there are no other alternatives open to us at this time.

Sincerely yours,

ROBERT VAN HOEK, M.D.
Assistant Surgeon General, Associate Administrator for Operations.

Dr. METTS. This is my second trip to Washington, D.C., to testify about the same situation. We in Savannah simply don't have the time or the energy to fight a political battle with HEW. All this does to me and to my people in Savannah is dilute our efforts in stroke and cardiovascular disease.

HEW, by making us politic and campaign to preserve our programs, which you have already established, is wrecking these programs.

The whole purpose of regional medical programs and the Partnership for Health was to provide real care to real people on a community level. We are doing this and we are doing it very well, and we, in Savannah, are implementing the spirit of this law.

Our Savannah program was conceived at a local level by a group of physicians interested in making available to the people in Savannah the practical application of university research.

To our way of thinking, we were doing what President Nixon and Congress has said should be done. We have now exhausted our efforts, so here we are once again, turning and appealing to the Senate for judgment and assistance.

We thank you for your kind attention.

Senator EAGLETON. The information you have submitted will be made part of the record.

(The information referred to follows:)

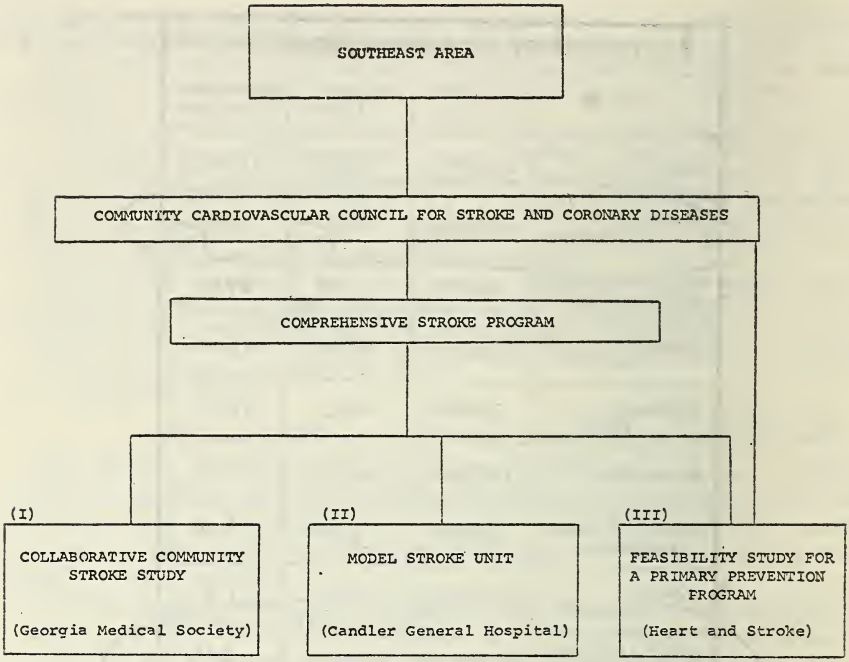
DISCRIMINATION AMONG HEALTH DOLLARS

DISORDER	ESTIMATED CASES	ANNUAL DEATHS	FEDERAL FUNDS EXPENDED/CASE
CANCER	940,000 (12th)	320,000 2nd	$193.00 1st
MENTAL RETARDATION	6,000,000 8th	NONE 12th	84.67 2nd
MUSCULAR DISTROPHY & NEUROMUSCULAR	200,000 15th	600 12th	24.00 3rd
MENTAL DISORDERS	19,000,000 4th	25,000 4th	19.04 4th
CEREBRAL PALSY	800,000 13th	NONE 12th	13.90 5th
BLINDNESS	1,217,000 11th	NONE 12th	13.48 6th
MULTIPLE SCLEROSIS & RELATED	500,000 14th	1,570 11th	8.00 7th
VENERAL DISEASES	1,000,000 10th	2,100 9th	7.19 8th
HEART & CIRCULATORY DISORDERS	25,000,000 1st	1,002,000 1st	6.44 9th
KIDNEY DISEASES	3,000,000 9th	19,930 5th	6.33 10th
CHRONIC RESPIRATORY	9,775,000 7th	33,000 3rd	2.60 11th
BIRTH DEFECTS	15,000,000 6th	18,000 6th	2.28 12th
ALCOHOLISM	6,000,000 8th	2,980 8th	1.04 13th
ARTHRITIS & RHEUMATITS	16,000,000 5th	2,130 10th	0.78 14th
ALLERGIC DISOARDERS	21,183,000 2nd	4,230 7th	0.52 15th
HEARING IMPAIRMENTS	20,000,000 3rd	NONE 12th	0.33 16th

REMARKS: HEART & CIRCULATORY DISORDERS —

- KILL 3-TIMES AS MANY PEOPLE AS ANY OTHER ONE DISORDER.
- EFFECT 3,817,000 MORE PEOPLE AS ANY OTHER ONE DISORDER.
- RECEIVE ONLY 1/30TH THE FUNDING PROVIDED 2ND LARGEST KILLER.
- RECEIVE ONLY 1/17TH THE FUNDING PROVIDED THE NON-KILLERS.

SOURCE OF STATISTICS: OCT 1969 "CHANGING TIMES"



MEMBERSHIP
COMMUNITY CARDIOVASCULAR COUNCIL

(15) Five Hospitals, 3 personnel each. (1) Administration, (2) Board Member, (3) Professional Person

(2) Public Health (M. D. and R. N.)
(1) City
(1) County
(1) Heart Association
(1) Georgia Medical Society
(1) Chatham Nursing Home
(1) Medical Arts Convalescent Home
(2) USPHS Hospital (1 administrative & 1 professional)
(1) Department of Vocational Rehabilitation
(1) Department of Family and Children Services
(1) Director of Collaborative Community Stroke Study
(1) Metropolitan Planning Commission
(1) United Community Services
(1) Protestant Population
(1) Catholic Population
(1) Jewish Population
(1) Savannah Speech and Hearing Center
(1) EOA
(1) Red Cross
(1) Armstrong State College
(1) Director, Comprehensive Stroke Unit
(1) Model Cities
(1) Memorial Rehabilitation Center

40 :: TOTAL

WHAT ABOUT SENATOR MAGNUSON'S RECOMMENDATION?

concluded that, in the long run, the objectives of the chronic disease control program, including the Heart Disease and Stroke Program could be much better achieved through the mechanisms of the Partnership for Health and Regional Medical Programs.

We believe that only within this context can a balanced evaluation be made of the plan to phase down in 1970 and phase out entirely in 1971 five chronic disease control programs in HSMHA. As a result of Executive and Congressional direction, the Department was faced with the need to reduce 1970 expenditures. Having already reached a decision to phase out the chronic disease control program eventually, the Department decided to take a first step in that direction in fiscal year 1970 and reduce planned 1970 obligations for the program.

It is important to note, however, that basic research in the chronic diseases continues under the auspices of the National Institutes of Health.

During this period of considerable fiscal restraint, we have hard decisions to make. We shall make these decisions with care and with knowledge of our obligation to strengthen and improve the Nation's health programs.

Sincerely yours,

Stanley W. Olson, M.D.
Director
Regional Medical Programs Service

SIGNED BY APPROXIMATELY 10,000 PERSONS
September 30, 1969

WE THE UNDERSIGNED REGISTERED VOTERS OF CHATHAM COUNTY DO HEREBY PETITION OUR ELECTED REPRESENTATIVES TO MAKE EVERY EFFORT TO PRESERVE OUR COMMUNITY ATTACK ON STROKE AND HEART DISEASE WHICH IS CURRENTLY BEING SPONSORED BY THE LOCAL MEDICAL ASSOCIATION, THE SAVANNAH COMMUNITY CARDIOVASCULAR COUNCIL, UNITED STATES PUBLIC HEALTH SERVICE AND THE GEORGIA REGIONAL MEDICAL PROGRAM. IN PARTICULAR WE REQUEST THAT YOU INTERCEDE WITH THE DEPARTMENT OF HEW AND PERSUADE THEM NOT TO ABOLISH THE HEART DISEASE AND STROKE CONTROL PROGRAM OF THE UNITED STATES PUBLIC HEALTH SERVICE.

WE FEEL THAT THESE PROJECTS SHOULD BE A NUMBER ONE PRIORITY IN THIS COMMUNITY AND FEEL THAT TO ABOLISH THIS PROGRAM WOULD SUBJECT OUR CITY TO AN IRREPARABLE LOSS IN THE FIELD OF COMMUNITY HEALTH.

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OFFICE OF
COMPTROLLER GENERAL
STATE CAPITOL
ATLANTA, GEORGIA 30334

JAMES L. BENTLEY
COMPTROLLER GENERAL

October 14, 1969

Dr. James C. Metts, Jr.
Chairman
Community Cardiovascular Council
110 W. Gaston Street
Savannah, Georgia 31401

Dear Jim:

It was a shock to learn that HEW contemplates cancellation of funds presently appropriated for the Heart Disease and Heart Control Program.

Yours is one of the most thorough and comprehensive as well as one of the most humane programs of research in the whole field of public health.

I am in communication with representatives in the private sector of insurance and business where I hope to establish some communication and ultimately some sponsorship and assistance for you. There is a responsibility in this area.

There is an even heavier responsibility in the government sector, however. We are spending millions telling people not to smoke when they already know that they shouldn't smoke. We're spending vast sums on mental health which is needed but the incidence of stroke and heart disease is even higher than problems in the mental health area. Your percentage needs are much higher and the allocation should be made on a basis compatible to needs.

I urge you to express yourself strongly and repeatedly to our friends in Congress and in HEW in Washington. I will do everything within my power to be of assistance.

Let me know when you see specific contacts which I should make in behalf of your program.

Good luck to you!

Sincerely,

James L. Bentley
Insurance Commissioner

JLB:ds

CITY OF SAVANNAH, GEORGIA
MODEL CITIES PROGRAM
1501 EAST BROAD STREET
SAVANNAH, GEORGIA 31401

October 7, 1969

Dr. J. C. Metts, Jr., Chairman
Savannah Community Cardiovascular Council
110 West Gaston Street
Savannah, Georgia 31401

Dear Dr. Metts:

The Savannah Model Cities Program has responded to the request of the Savannah Community Cardiovascular Council by writing Senators Russell, Talmadge, and Representative Hagan requesting them to support the continued funding of the Heart Disease and Stroke Control Program.

The Savannah Model Cities Program solidly supports the work of the Council and its program of attack on heart disease and stroke control. Diseases such as these take a heavy toll of Savannah-Chatham County citizens.

A major portion of the Model Cities Program is devoted to bettering existing conditions in health. Please be assured that you have our support in your endeavor to see this vital program of heart disease and stroke control continued.

Sincerely,

Thomas Euric Sears
Director

TES:bbc

ALL AMERICA CITY 1969

STATE OF GEORGIA)
) IN THE COMMISSIONERS' COURT
COUNTY OF CHATHAM)

WHEREAS, a broad-based comprehensive program for the control of stroke and heart disease has been undertaken in Chatham County in close cooperation with the members of the Heart Disease and Stroke Control Program; and

WHEREAS, the continuation of this collaborative community stroke program is dependent in great measure on federal financing; and

WHEREAS, it is the conviction of the Commissioners of Chatham County and Ex-Officio Judges Thereof that the highest service a government can perform is that of enhancing the health and general welfare of its citizens;

NOW, THEREFORE, BE IT RESOLVED by the Commissioners of Chatham County and Ex-Officio Judges Thereof that they respectfully request the Department of Health, Education and Welfare not to discontinue its support of the Heart Disease and Stroke Control Program, but to continue full support of this program for the benefit of all citizens of this community;

AND, BE IT FURTHER RESOLVED that other public and private agencies within Chatham County be called on to join in this urgent request for a continuation of this vitally needed federal support.

IN OPEN COURT, this 10th day of October, 1969.

C. C. C.
C. C. C.
C. C. C.
C. C. C.
C. C. C.
C. C. C.
C. C. C.

R E S O L U T I O N

WHEREAS, Savannah's Collaborative Community Stroke Study Program constitutes a unique medical effort to overcome Heart Disease, the nation's Number One killer and also the Number One killer in Chatham County, which has the highest imcidence of Heart Disease and Stroke in the United States; and

WHEREAS, the results of research and treatment methods developed through Savannah's Collaborative Community Stroke Program will serve as a model for the nation to follow; and

WHEREAS, the success of this program is dependent in a great measure upon funds from the federal government to finance certain aspects of the work that is required; and

WHEREAS, current efforts by the U. S. Department of Health, Education and Welfare to cut back on certain allocations are threatening to abolish the national Heart Disease and Stroke Control Program, with resulting adverse impact upon the local program; and

WHEREAS, the highest service that a government can perform is one that enhances the health of citizens; therefore

BE IT RESOLVED by The Mayor and Aldermen of the City of Savannah, in Council assembled, that the U. S. Department of Health, Education and Welfare is implored not to abolish the Heart Disease and Stroke Control Program but to continue full support of said program; and

BE IT FURTHER RESOLVED that citizens of Savannah and Chatham County are invited to join in a community effort to preserve the Heart Disease and Stroke Control Program by writing to the leaders of Congress urging them to consider the serious consequences affecting the health of the nation should the program be discontinued by the federal government.

[From the Savannah Morning News, Monday, Sept. 29, 1969]

FIGHT FOR HEART FUNDS

We urge the Dept. of Health, Education and Welfare to reconsider any plan to abolish the Heart Disease and Stroke Control Program here and we think it is mandatory for our elected officials, both in Chatham and in Washington, to fight to keep this vital program.

It wasn't too long ago that this area was cited as having the highest incidence rate from the very diseases now under study and, as in the squabble over the keeping of the U.S. Public Health Service Hospital in Savannah, it raises serious questions as to HEW's actual concern about health. We would hate to see any program, whatever its location, looking into the most common killer of Americans have its efforts curtailed simply because a budget has to be rearranged.

Moreover, the program itself seems to be a model of community cooperation and concern, and the fear that funds might not be renewed for a comprehensive stroke unit planned for Candler Hospital also makes one wonder about the wisdom of the government's possible move.

Congressman G. Elliott Hagan has urged a letter-writing campaign on the part of concerned citizens who feel such a fund cut in this health area is foolish and who wish the program to continue. We agree. But at the same time we do not think it should even take one letter to show the budget-watchers that the proposed fund cut would retard new knowledge about the causes of heart diseases. One medical spokesman here has already cited the local program as having potential of international importance, and when one glances at the statistics involving the number of deaths attributed to heart disease it should take little urging to demand a commitment of funds.

It remains strange why a cutoff was even proposed in the first place. That might be worth a little investigation, too.

[From the Savannah Evening Press, Savannah, Ga., Thursday, Nov. 13, 1969]

Questionable Economizing

We support the Nixon Administration's effort to trim federal spending. A reduction of government expenditures is one means of holding down inflation and a closer scrutiny of domestic spending by all government agencies is long overdue. When economies and spending cutbacks come, we can't expect them not to touch Georgia. But we still believe that ending the heart disease and stroke programs in Savannah would be a grave mistake.

Although these programs are of importance to Savannah, where both heart disease and stroke are major killers, they are of equal significance to the rest of the nation. They are the sort of programs which should not be given the ax.

Discretion and judgment are required in deciding where economies should be levied. A spokesman for the national Heart Disease and Stroke Program has said, "We would rather put what money we have into the regional medical program for heart, cancer and stroke work rather than supporting a number of small efforts." This applies to the Savannah programs a description which we don't believe is entirely accurate. They may be a "small effort" as far as cost is concerned, but they constitute a model program which was expected to be used by other researchers in other communities and even other nations.

Every fund cutback is opposed by someone, it is true, and economy would be impossible if the Administration called off every spending reduction that draws criticism. But wise economy is applied to programs which are inefficiently operated or unnecessarily expensive, superfluous or of questionable use. We are sure that there are plenty of programs around that fall into those categories; the heart disease and stroke program in Savannah don't.

Hoping that there is still a chance to save this valuable research project we urge officials to press for a change in the plan to abolish it.

[From the Savannah Morning News, Friday, Nov. 14, 1969]

Stroke Program Is Vital

That necessary health programs should be among the priorities of government would seem to be an obvious fact, and one expects that they would be among the last on the list scheduled for budget cuts.

That is why we urge retention of funds for the local programs dealing with strokes and heart disease—the major killers of Americans. Today a delegation from Savannah meets with Health, Education, and Welfare officils in Washington to urge that funds be retained, and full community support is given.

Because the Savannah area also leads the nation with the highest incident and death rate from strokes, research in this field is even more keenly demanded here. Already, work has gone on. It would not only be interrupted but set back

by any budget cuts. The pill is even more bitter when one witnesses wasteful spending in other areas of government, and though the Nixon Administration is trying to reduce that waste we think health care becomes something more than a set of budget figures to consider.

Indeed, to curtail a program before it has had adequate opportunity to prove its worth seems to be an even greater example of waste.

We urge federal officials to reconsider their plans. We also urge our own elected representatives to give their full support to the Savannah program. We believe it is vital. We believe it should be retained.

[From the Atlanta Journal and Constitution, Sunday, Nov. 16, 1969]

HEART FUND CUT IS FALSE ECONOMY

The EDITORS: Unbeknownst to a majority of American citizens, the Department of Health, Education and Welfare is moving behind the scenes to abolish one of its own children—the Heart Disease and Stroke Control Program. In the councils of those concerned with disease of the heart and great vessels, this is causing great concern, and it should. Cardiovascular diseases account for roughly half of all deaths in the United States each year—over one million people. The Heart Disease and Stroke Control program has been the only nation-wide agency to perform investigative work in these diseases at a community level, the only agency to attack the problems of coronary heart disease and stroke in a comprehensive manner, and the only agency to attempt to apply basic physiological research for control and prevention of these diseases.

This program is being abolished as one step in the effort to economize. Its abolition will save about $2.4 million, at a time when losses due to cardiovascular diseases (by the government's own estimate) are costing the nation over $20 billion annually and untold human suffering. It is obvious to all except those who are only interested in channeling HEW monies into welfare oriented programs such as Medicare for immediate political gain that this move is a false economy. . . .

The last ray of hope seems to be the Senate Sub-Committee on Health Appropriations. If funds can be approved here for continuation of the Heart Disease and Stroke Control Program, there is hope. . . .

We Americans are prone to sudden death at an early age from diseases which, if caused by infectious agents, would be labeled epidemics. The epidemic of coronary disease and stroke must be stopped. Perhaps it is not too late to let our senators know where we stand.

JAMES C. METTS JR., M.D.,
Chairman, Community Cardiovascular Council, Savannah.

[From the Medical World News, Nov. 28, 1969]

A CITY SPEAKS: "SAVE OUR STROKE PROGRAM"

Savannah, Ga., is a pleasant tidewater town known for Eli Whitney's first practical cotton gin, magnificent antebellum architecture, and the nation's highest incidence of stroke—this year it will claim 700 residents. For the past two years, town doctors have been pouring their time, talent, and money into a community program to cut this figure. Now, having promised aid and personnel, the federal government seems to be backing out. The doctors are fighting back.

"Just when our program is about to bear fruit, the Nixon Administration, in a foolhardy move to save money, is threatening to cripple severely our efforts by doing away with the Heart Disease and Stroke Control Program that backs up our program," says internist James C. Metts Jr. (above), the spark plug behind the community effort and leader of Savannah's current save-the-stroke-program campaign. At stake are three major activities:

The Georgia Regional Medical Program has given Savannah a $9,000 grant to begin planning a community-wide sproke prevention program.

The PHS heart disease control program and the Georgia Medical Society last March began a two-year survey of stroke incidence in Savannah and surrounding Chatham County. The PHA has identical studies, part of a nation-wide stroke survey, under way in Salt Lake City, where stroke incidence is lowest, Berkeley-Oakland and Orange County in California, and Birmingham, Hagerstown (Md.), and Nassau County (N.Y.).

This past summer, the PHS awarded a $99,000 three-year contract to Chandler General Hospital, second oldest continuously operating hospital in the U.S., to establish an experimental intensive care unit to demonstrate new methods of treating and rehabilitating stroke victims.

Savannah's problems aren't simply financial; indeed, most of this money had already been committed. What worries Dr. Metts and his community's cardiovascular council, made up of representatives of 50 government, civic, and consumer-health organizations, is that these funds are practically useless without the five PHS personnel assigned to help spend it. And if the Heart Disease and Stroke Control Program closes on June 30, 1970, as predicted (MWN, Oct. 10), these stroke experts will be pulled out. Nationwide, about 350 employees of various chronic disease programs stand to be reassigned. Says Dr. Carroll Quinlan, head of the stroke unit in Washington: "No matter how much money they have, they can't do it without the professional help we can give them "

On the PHS team now operating in Savannah as part of the six-community stroke survey, statistician Calvin Paul is collecting baseline data on recent stroke patients in the area, to be used in measuring the effectiveness of future stroke prevention efforts. Helping evaluate the care stroke patients get in local hospitals are PHS Commissioned Corps neurologist Thomas Swift, public health nurse Agnes Newell, social worker Charles Wilson, and physical therapist Hugh Moffett. This chore is supposed to be done before the new stroke unit at Candler General opens next year. Attending physicians willing, Dr. Swift thoroughly examines every stroke patient admitted to the hospital or treated at home. And his team evaluates care right down to the type of home environment the patient returns to when discharged from the hospital. "If the patient gets better, we'll know exactly why," he comments.

These data, which Dr. Swift says "exist nowhere today," plus data collected by statistician Paul, ought to be helpful to stroke programs throughout the country. And one aim of the PHS two-year stroke survey is to identify the factors responsible for a true higher incidence of stroke in the Southeast than in any other part of the U.S. At the same time, the PHS team is also instrucing local physicians and other health professionals in the care of stroke patients.

Taking dead aim on economics that would permit such expertise to be lost, ever since the September day he was tipped off to his program's impending elimination, Dr. Metts has coolly cranked up a massive community campaign. It has not gone unnoticed in Washington.

First, he broke the news to the 50 members of the community cardiovascular council that while the contract to operate the experimental intensive care unit at Candler General would not be touched, the PHS experts would not be coming around. Dr. Metts and his co-workers got community support, too. Says Mayor J. Curtis Lewis: "The city and county governments are behind them 100%."

Farther afield, Dr Metts fired off letters to members of House and Senate appropriations committees and was invited to testify before the Senate health appropriations subcommittee. And Sen. Ralph Yarborough (D-Dex.), chairman of the Labor and Public Welfare Committee, and Sen. Richard Russell (D-Ga.), chairman of the Appropriations Committee, both expressed their support. Dr. Metts, city alderman D. Boyd Yarley, and John W. Osterweil, a member of the model cities staff in Savannah, journeyed to Atlanta to consult with Gov. Lester Maddox. Georgia Republican chairman Wiley Wasden contacted HEW Secretary Robert H. Finch. And City Manager Picot Floyd met with Creed Black, HEW assistant secretary for legislation and a former executive editor of the Savannth newspapers.

Local newspapers and radio and television programs picked up the ball. Petitions, circulated at hospitals, local factories, and even the county fair. were signed by over 7,000 persons.

All of the area's 125 physicians are involved in the existing stroke program in some way, and they feel strongly about the need for federal support of men and money. Current plans include public education programs to advise residents of stroke risk factors and to educate physicians in the early signs of impending stroke, such as transient ischemic attacks. "We also plan to intervene directly in selected patients through angiography and carotid artery surgery," says radiologist Edgar J. Filson, who is helping to lay the groundwork for a prevention program.

But it is the details of planning such a project, with the need for controls and evaluation, that are beyond local competence. "What do we do next?" asks Dr. Filson. "How do we screen these people? We need expert help. If this program goes under, we doctors won't lose anything—but our community loses."

Meanwhile, across town, in the high-ceilinged office where he and his father practice (the father for 45 years, the son for eight), Dr. Metts sits exhausted but still unaffected. Save-the-stroke-program petitions pile high on his desk. "I get sick and tired of seeing people in the shape I see 'em in when they come in here. The best treatment for a stroke is not to have one. And that's what we're trying to do here in Savannah—if the federal government will only let us."

CURRICULUM VITAE

James Clayton Metts, Jr., Board Certified Internist. Private practice of Internal Medicine in Savannah, Georgia, since 1961.

Graduated University of North Carolina, Chapel Hill, North Carolina, 1951, with a B.S. in Chemistry.

Graduated from the Medical College of Georgia, Augusta, Georgia, in 1955, an M.D. Degree. Rotating internship and six months of residency training in the Presbyterian-St. Lukes Hospital, Chicago, Illinois. Served 24 months in the United States Air Force as a physician specializing in internal medicine.

Returned to Eugene Talmadge Memorial Hospital, Augusta, Georgia, for thirty additional months of residency training in internal medicine.

Certified by the Internal Medicine Board in 1964.

Positions Held: Chief of Medicine, Memorial Hospital, 1965, Savannah, Georgia; President of the First District Medical Association of Georgia in 1968; Chairman, Community Cardiovascular Council of Savannah, Georgia; Director, Comprehensive Stroke Unit, Candler General Hospital, Savannah, Georgia; Chairman, Candler General Hospital's Local Advisory Group to the Georgia Regional Medical Program; Chairman, Coronary Care Unit, Candler General Hospital; President, Better Business Bureau, Savannah, Georgia; President, Southern Endocrine Society, Augusta, Georgia, 1960.

Papers Given: Hodgkin's Disease: Manifestations in the Peripheral Blood, American College of Physicians, 1960; *Sickle Cell Disease: Sixteen Cases with Prolonged Survival,* American College of Phyiscians, 1960; *The Clinical Application of Lymph Node Aspiration,* First District Medical Society of Georgia, April 12, 1961.

Papers published: Addison's Disease, The Journa of the Medical Association of the State of Alabama, Vol. 30, November 1960; *Endocrinopathics and Infertility,* "Fertility and Sterility", Vol. 10, No. 4, July-August 1959; *Several Extrapyramidal Motor Activity Induced By Prochlorperazine.* New England Journal of Medicine, 262–353–354, February 18, 1960.

Papers Written But Not Published: Erythrocyte Sickling in Several Species of Animals With Electrophoretic Characterization Of Their Hemoglobin Types.

Senator EAGLETON. Thank you, Doctor. Your program in Savannah, does that service not only people in, shall we say, the metropolitan area of Savannah, but out into the State as well?

Dr. METTS. It serves within the confines of Chatham County. It was necessary to restrict it geographically because a portion of this is a scientific study requiring a controlled population.

We hope to adopt a module of some sort. If this works in Chatham County, we would plug into some other county that has the same problem.

Senator EAGLETON. Thank you, Doctor, very much. We appreciate your appearance today.

At this point in the record, without objection, I will place a statement by Paul D. Ward, executive director, California Committee on Regional Medical Programs.

(The prepared statement of Mr. Ward follows:)

PREPARED STATEMENT BY PAUL D. WARD, EXECUTIVE DIRECTOR, CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS

We are pleased to appear in support of S. 3355 by Senator Yarborough and others, which would amend and extend the current legislative authorization for Regional Medical Programs. I serve as Executive Director of the California Committee on Regional Medical Programs, which is a non-profit corporation.

founded principally to manage the overall programs in the California Region. In terms of population, our region is the largest of the fifty-five existing regions. Its distribution of resources—both manpower and facilities—as well as its variety of approaches to medical care and its diversity of problems, make this region an interesting point of observation for judging the possibilities of obtaining the objectives and original legislative intent of the program.

The program, thus far, has enjoyed broad support from the health-related professions, the leadership of health facilities and the public. While pursuing its objectives, relatively little adverse reaction has been generated. Additionally, there has been a greater involvement of people on a voluntary basis than in any other program of recent vintage. It is with these considerations in mind that the following comments on S. 3355 are made.

One of the major contributing factors to the success of RMP in California has been the emphasis on categorical diseases. We support the broadening of the categorical approach as expressed in S. 3355 and we would emphasize that we believe any actions to eliminate the categorical approach would cause irreparable harm to the progress that has been made.

Although ideally it may be more desirable to view comprehensively the health of man and his community, from a practical point individuals become involved and committed to goals because of their interest in specific matters. RMP has been built on the specialist helping the less specialized; it has attracted people, both lay and professional, because of their interest in specific pursuits, yet it has been able to bring them all together at certain points which produce benefits over and above the specific categories concerned.

Lay people have become involved because of their interest in specific areas and they can identify with a specific category. Specialists from the medical schools and medical centers become involved because they can relate to specific objectives. Facilities usually seek aid from the program because their services are weak in a given disease area. Further, patients are usually treated for problems that are categorical, and hopefully, not many patients are ill comprehensively.

This program has been built on beginning with specific problems to which people can relate their specific interests and abilities and then building toward the overall improvement in the organization and delivery of health care. To completely eliminate the categorical approach at this time would be to destroy much of the foundation on which the program has been built. Significant numbers of people now voluntarily involved would believe that the program no longer concerns them and would be inclined to adopt the attitude of "letting the other guy do it."

On the other side, we have not witnessed any serious curtailment of the program because of the categorical approach. Some regional advisory groups have pondered the exact parameters of the program, but the real limitation on the program has been the available dollars once the planning gained momentum, not the authority to engage in an unlimited pursuit of the problems of health care.

We believe that the sums set forth in S. 3355 as authorized amounts are realistic, although more conservative than the early planning and development efforts had been geared for. The plateauing of funds now in effect and the enforced carryover of funds has been disastrous to some of our best planning, but our planning could be regeared appropriately to meet the levels set forth. I mention this because the program uses voluntary cooperative arrangements as its major means of gaining improvements. The arrangements have proven perishable if held in abeyance for long periods of time awaiting funding. They essentially are agreements between people, facilities, local government and others to perform in a given way together. If the agreements are slow to be put into effect, people either move on to other concerns or they forget what they agreed to. The planning then has to be commenced anew and the original planning dollars may have been wasted.

Some of the concerns can be seen from the following brief descriptions of certain of our programs.

The California RMP has initiated a confederation of coronary care units. The confederation has trained 1,250 nurses, 105 physicians and has provided consultation to hospitals on equipment and construction needs for CCU's. Physicians from throughout the region meet regularly to coordinate planning for CCU's to assure adequate distribution of care throughout the region without developing more than will be properly utilized.

Activities within the confederation have, in the first year, increased the pool of available trained CCU nurses by 57% in the Los Angeles area. Even so, the training programs we have are producing fewer than half the numbers of nurses we need in the region.

Those hospitals which are too small to justify a unit for coronary patients exclusively are being encouraged to include specialized coronary care equipment within intensive care units. A program operated through Pacific Medical Center in San Francisco has provided a training program for physicians in small hospitals to learn ICU techniques. This program provides in-residence training at the San Francisco hospital for practicing physicians, followed by consultation visits from PMC staff to the local hospitals. The support for this program has been overwhelming. Many rewarding comments have been made publicly about it. Dr. John W. Derbyshire, of Palm Drive Hospital in Sebastopol, California, stated that before the program began, several of the ICU procedures were not used or were infrequently used because of lack of confident understanding of their applicability. Now, daily application electrocardiographic monitoring is done. External pacing, he has said, has saved the lives of at least two patients. Because funds have been cut back, the program has not been able to meet the demands from the community hospitals for the training offered. Seventy physicians are currently on the waiting list. Included are doctors from the hospital at Garberville, California, which is 60 miles from another hospital. It has ICU equipment which is not being properly utilized because the staff does not feel qualified to do so. The hospital is eager to have its staff participate in the project, but because of a long waiting list and reduced program funds, these doctors must wait until October to participate, and there is no assurance that there will be enough funds for the project to continue that long.

The accomplishments of the coronary care programs are that we have developed a group of people who understand CCU's and who are working together on their planning. We have learned much about how best to train the doctors and nurses needed to work in and manage these units. We have trained many people who have the capability of training others. Now that we have reached the point where we can do much in the region, we fear that efforts to date will be lost because funds are not available to go on.

Our cancer program was not begun as early as that concerned with coronary care. We are only beginning to see improvements actually reach the patient. The proper management of cancer patients requires highly trained and experienced specialists working in close cooperation. Just this kind of cooperation and the needed specialists are making available in Northern California many of the refinements in cancer therapy that tend to be concentrated in metropilitan cancer centers. By the end of the first year of operation, this project will involve 20 institutions, 200 health providers will receive training, and at least 500 cancer victims will benefit from the program.

Included in the program are cancer consultation services, radiation physics support, a computerized data retrieval system, and educational activities for physicians, nurses and other allied health professionals. Under the consultation services program, specialists from the cancer centers at the University of California and Mount Zion Hospitals in San Francisco visit the participating hospitals—as much as 300 miles away—to share with other doctors their expertise in radiation therapy, chemotherapy, and cancer surgery. Each community will be encouraged to develop its own cancer management team, and assistance will be available as needed in the planning of cancer treatment facilities. A computerized data retrieval service will serve as a memory bank of information about individual patients. It will offer participating hospitals the basis for evaluating their performance in cancer treatment and will assist in the evaluation of the program as a whole.

A unique feature of the program is the telecommunications link between San Francisco and community hospitals. The hookup transmits the patient's diagrammatic contour and clinical findings by teleprinter to the center in a few minutes. The displayed information is examined by experts in determining how radiation can be applied most beneficially to a patient. A detailed treatment plan is calculated and transmitted back to the community hospital. During this time the physician also can discuss by telephone such matters as the amount of radiation dosage the patient should receive and the best angle for administering radiation into the patient. This communications system enables cancer victims to stay in their home communities and receive benefits of the best modern treatment methods, no matter how far they are away from the major medical centers. As this program is refined, it eventually can be blended into the normal funding mechanisms for patient care.

Planning programs for the care of stroke patients has been a slow and laborious process due largely to the once widely held belief that nothing much could be done for these patients. The massive crippling effects of the disease, and the

multiplicity of medical and allied health personnel required to carry out the time consuming process of rehabilitation caused many communities to virtually ignore the problem. However, in California four farsighted projects have been processed through the planning stage and one has had initial funding.

After less than six months of operation, our one funded project has already begun to show promising results. Fifty-five physicians have received specialized training in the care of the stroke patient and have returned to their community general hospitals and local practices with an awareness that the stroke patient is not hopeless and with knowledge of what can be done for him. Eleven speech therapists are now in training in the project, gaining specialized knowledge on stroke rehabilitation.

One of the most significant effects of this project has been the new, enthusiastic, almost evangelical, attitude of the community physicians who have been through the training program. They no longer file their own stroke patients away in a nursing home for living storage until death. Instead, they are insisting that their patients be placed in extended care facilities which have personnel knowledgeable in stroke rehabilitation. Such facilities are extremely rare, but they hopefully will become more abundant as the project itself achieves its objective of training skilled stroke rehabilitation teams from the local extended care facilities and hospitals. Thus, it is imperative that full future funding of this project be assured.

Of even greater concern, however, is the need to assure that this one project not be allowed to exist in isolation. Three other projects, in other areas of the state, are in abeyance due to lack of funding. Each has many of the elements of the one funded project, and each has other elements designed to test new and different concepts in stroke care. A Statewide Stroke Task Force has already done all of the necessary groundwork to standardize records among, and elicit comparable data from, these projects. Therefore, if the others could get started the system exists for comparing one against another, thereby identifying for the advancement of the future care of all stroke patients, the most effective way of providing treatment and rehabilitation.

We support the proposed addition of language in S. 3355 which would emphasize the need to improve primary care and to create a bond between it and specialized care. We believe we have made a significant beginning in this regard with the planning in Watts and other lower income areas.

In northeastern San Fernando Valley, in Pacoima and five other contiguous communities which have been without proper health services, a vigorous drive is under way to establish useful transportation, a corps of neighborhood aides, new hospital and clinic services and a highly unusual consortium involving high schools, hospitals, colleges, the medical society and several health agencies in the organization of training programs for the allied health professions.

In the Watts area of Los Angeles an RMP program tied closely to an all-out effort on behalf of county government is deeply involving the community in programs designed to materially improve the levels of medical care for the residents and to greatly increase opportunities for the training of minority group members in medicine and allied health professions. One project will be a "health store," an idea originated and to be implemented by a community youth group with RMP support. The "health store" will provide counseling, referral and a site for screening and other service programs. While areas such as Watts are totally disillusioned by studies conducted by outsiders who visit for a while and then disappear forever, under RMP they are themselves conducting meaningful studies which will lead to community action programs.

The RMP sponsored Drew Postgraduate School of Medicine will be located within the new Martin Luther King General Hospital being built by the County of Los Angeles and will provide postgraduate training for physicians, faculty for the county's training program for allied health personnel, and medical staff services for the hospitalized patients. The county has made a deep commitment to this effort, both in money and in the assignment of some of its best available personnel. When the hospital opens, the Drew School faculty will be jointly financed by RMP and the county for a period of time until the school becomes fully self-sustaining. Under RMP auspices solely at the present time, a nationwide search and recruitment program is going on to get faculty aboard and do the massive planning necessary to begin operation of a large modern medical center and medical school in the fall of 1971.

When in full operation the Drew School will be overseeing the medical staff of a hospital serving over 500,000 persons who have had only minimal services to date. In addition, a comprehensive ambulatory care program will be con-

ducted in the immediate Watts area for more than 25,000 residents through the hospital out-patient department and satellite centers. The school will eventually turn out in excess of 100 physicians a year with graduate medical training in community medicine, pediatrics, internal medicine and seven other specialties. It will also contribute significant faculty resources to the allied health personnel training program which will train several hundred nurses, therapists and technicians per year, largely drawn from the unemployed or marginally employed citizens of the area. This immense cooperative effort, involving a community, voluntary agencies, and all levels of government could well serve as a national prototype as an urban ghetto program which simultaneously tackles problems of education, medical care, and employment.

We support the addition of language in S. 3355 which would authorize construction in addition to the present authorization for alteration and renovation. Several of the programs in developing needed facilities for educational purposes, coronary care units and the like have experienced difficulty with the narrow interpretation placed upon alteration and renovation. It should be made clear, however, that construction in this sense could not mean the creation of entire new facilities and centers, since the level of authorization within the bill is not sufficient to contemplate this type of construcion and at the same time support the many other planning and operational efforts now contemplated by the regions.

We concur with the proposal in S. 3355 which would bring the Regional Medical Programs into a closer relationship with Comprehensive Health Planning. We would hope, however, that this relationship could be structured at the B Agency level only.

To date most CHP agencies seem to have taken the limited approach toward health proposals that they have the right of approval or disapproval of a project proposal or a proposed facility advanced for funding at the time the funding is aplied for. Upon further analysis, however, this seems to be both a frustrating and wasteful approach to the problem of coordination. Ideally, if the planning is to be coordinated in the most efficient and least harassing manner, it should be coordinated on a staff level beginning at the inception of a concept until it matures into a completed project or facility proposal. This means that CHP somehow should provide the forum for coordinating the planning from the day it begins until it is a completed proposal, and upon completion, there should be no need for a final review and approval process. Each one of the steps in the planning process should have had the benefit of the coordinating process. A conflict should be resolved at that point in planning when it is first discernible, not after it has been woven into a completed project.

Senator Eagleton. We have received statements from Senator Hart, of Michigan; Senator Hartke, of Indiana; Senator Jackson, of Washington; and Senator Montoya, of New Mexico. I order them printed at this point in the record.

STATEMENT OF HON. PHILIP A. HART, A U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator Hart. Mr. Chairman, I commend you on your introduction of S. 3355, which will extend and improve the existing programs of education, research, training, and demonstrations in the fields of heart disease, cancer, stroke, and other major diseases. I am delighted to be a cosponsor of this legislation.

I support the major thrust of this bill, extending our work with heart, cancer, and stroke under the regional medical program through June 30, 1973, specifically adding kidney disease to the program, and increasing the funding. Additionally, I applaud very especially your extending coverage to other major diseases such as arthritis.

In your explanation of S. 3355, as it appeared in the Congressional Record of January 29, 1970, Mr. Chairman, you made clear that arthritis was included in the scope of "other major diseases," and I hope the committee report will also make this explicit.

As our former colleague, Senator Smathers, told the Senate Appropriations Committee last fall, almost 17 million persons in the United States suffer from arthritis. In wage losses, medical care costs, welfare and other support payments, the total annual cost to our national economy due to arthritis exceeds $3½ billion annually.

The Nation's first demonstration arthritis control center was established in Michigan last year. It is a collaborative project of the University of Michigan in Ann Arbor and the Henry Ford Hospital in Detroit; $450,000 was made available, under the chronic disease control program, for the first year of a planned 5-year program.

The center has had a precarious existence so far—a "Perils of Pauline" life. The House of Representatives struck the $24 million in the 1971 HEW appropriation for the chronic disease control program, which by then had been "merged" into the regional medical program. The Senate restored the cut. The House accepted the Senate figure. Then came the President's veto, and as of this date, we do not know where we stand.

For the incredible history of the chronic disease program, which has been the object of repeated reorganization, regrouping, and merging over a period of years, I attach a memorandum prepared at my request by the Legislative Reference Service of the Library of Congress.

Officials of the Michigan Center had asked to appear before your committee to explain the work they are doing. I commend to you their written testimony which will be sent in by Dr. Ivan F. Duff. Briefly, the major goals of the program are—

(1) the initiation of a demonstration that early diagnosis and comprehensive treatment of arthritis will prevent, delay, or reduce the development of joint deformity and functional disability and will result in measurable economic benefits;

(2) to improve and expand the existing capacities in the four participating hospitals; that is, University Hospital, Henry Ford Hospital, Ann Arbor Veterans' Administration Hospital, and Wayne County General Hospital, so as to provide optimum, comprehensive, continuing, and exemplary care for adults and children with arthritis;

(3) to exert a greater degree of beneficial influence on the medical care received by arthritic patients in Michigan and adjoining geographic areas served by the participating institutions; a major mechanism for achieving this goal was to be by close cooperation with the statewide arthritis consultation and teaching clinics sponsored by the Michigan Chapter of the Arthritis Foundation;

(4) to translate available advances in clinical rheumatology into productive educational programs for medical students, resident and practicing physicians, allied professional paramedical personnel, including nurses, social workers, physical therapists, occupational therapists, et cetera, as well as the general public; and

(5) to facilitate high-quality clinical research in arthritis.

It is time for this work to be firmly incorporated in the regional medical program, to be assured of a degree of continuity and to be adequately funded.

Mr. Chairman, I hope your committee will act promptly and favorably on S. 3355, so that the health of our people may receive the priority it deserves.

Thank you very much.

THE LIBRARY OF CONGRESS,
LEGISLATIVE REFERENCE SERVICE,
Washington, D.C., December 22, 1969.

To: Hon. Philip A. Hart.
From: American Law Division.
Subject: Legislative history of the diabetes and arthritis control program of the Public Health Service.

In checking HEW appropriations over the past ten years we found that although grants had been made to States for arthritis and diabetes control under NIH programs within this time period, the diabetes and arthritis control program came into existence in 1961–1962. Legislation had been introduced in the 86th Congress to expand community services for health care of aged persons, but no action was taken on this legislation. However, the Public Health Service anticipated the eventual passage of health care for the aged legislation and requested additonal funds under its Bureau of State Services which was being regrouped into the Bureau of Environmental Health and the Bureau of Community Health pending enactment of this legislation.

On February 28, 1961, Mr. Harris introduced H.R. 4998, a bill to assist in expanding and improving community facilities and services for the health care of aged and other persons. H.R. 4998 was approved as Public Law 395 on October 5, 1961. A legislative history of this bill is attached.

The diabetes and arthritis control program was set up under the Bureau of Community Health. We have duplicated pages from the House and Senate appropriations hearings for 1964 and 1965, which describe this program.

On March 2, 1966, Mr. Hill introduced S. 3008, a bill to amend the Public Service Act to promote and assist in the extension and improvement of comprehensive health planning and public health services and to provide for a more effective use of available Federal Funds of such planning and services. S. 3008 became Public Law 89–749 on November 3, 1966.

This "Comprehensive Health Planning and Services Act" provided the grant support for the Chronic Disease Center which was created January 1, 1967, in a complete reorganization of the Public Health Service. HEW's appropriation request for 1969 shows the National Center for Chronic Diseases requesting an increase of $1,942,000 over their 1968 budget of $27,837,000.

In April of 1968, the Public Health Service again re-grouped and this time we have the National Center of Chronic Diseases under the regional medical programs service under the National Center for Health Services Research and Development within the newly created Health Services and Mental Health Administration (note page 12 of Part III of the House Appropriations Committee hearings for HEW for 1970).

STATEMENT OF HON. VANCE HARTKE, A U.S. SENATOR FROM THE STATE OF INDIANA

Mr. Chairman, members of the subcommittee, I most earnestly support S. 3355, to amend title IX of the Public Health Service Act so as to extend and improve the existing program relating to education, research, training, and demonstrations in the fields of heart disease, cancer, stroke, and other major diseases and conditions, and for other purposes. I am particularly desirous to see that the scope of the regional medical programs be extended to include kidney disease and other major diseases and conditions.

The need for the Federal Government to provide assistance to those citizens who suffer from terminal kidney disease has been evident to many of us for some time. In June of 1968 and again in June of 1969, I proposed legislation to amend the Public Health Service Act to provide assistance to certain non-Federal institutions, agencies, and orga-

nizations for the establishment and operation of cooperative and community programs for patients with kidney disease and for the conduct of training related to such programs. The bill now before this subcommittee seeks to begin to meet the needs of those who suffer from kidney disease through the regional medical program that Congress created in 1965.

In 1968, I reported to Congress that some 6,000 Americans would die needlessly of this dreadful disease because they simply did not have the money or the facilities available to them to prevent their slow and agonizing death. The statistics have become only more grim and the need only more acute in the last 2 years. Current estimates are that close to 8,000 people will die this year from terminal kidney disease because we are not able to deliver the fruits of our research in this field.

In 1968, of the estimated 7,000 persons with chronic uremia who were medically suitable for treatment, only 550 were able to secure dialysis treatment through existing facilities. Tragically, little has been done to alter this situation. Most States have been hesitant to implement programs to meet the need of those who are victims of kidney failure. A similar lack of initiative characterizes the role played by private philanthropy. Part of the explanation lies in the cost of treatment.

Dialysis treatment in a hospital can be as expensive as $10,000 to $30,000 a year. Rising hospital costs further exacerbate the problem. If the patient is able to undergo dialysis treatment in the home, and currently about 200 people are being treated by machine dialysis at home, costs may be reduced by one-half, or more. It is estimated that the cost of home dialysis varies between $11,000 and $14,000 during the first year, and between $3,000 and $7,500 during subsequent years. But home care requires a capable and trained relative of the patient to help him operate the machinery.

Medical insurance offers little or no assistance in helping patients meet the expenses of treatment. The vast majority of health insurance companies do not presently include chronic dialysis in their policy coverage.

Persons covered by the Federal medicare program receive very small amounts of financial assistance. Medicaid provides a little more, some $25 for each day in hospital dialysis treatment, but simple arithmetic tells us how minimal this aid really is.

In 1965 and 1966, the Federal Government took some action in an attempt to begin to increase the availability of dialysis by sponsoring demonstration projects to show the possibility of widespread use of these artificial kidneys. Grants totaling $2.5 million were paid to help maintain kidney centers and permit them to admit patients who could not afford treatment themselves. But these funds were only for research or treatment demonstrations, and no for general daily patient care. While the centers knew these grants might not be renewed when they expired, many of them nevertheless hoped that the Government would not cut them off, once having made this commitment. But their hopes were changed to disappointments when the economy drive caused by the Vietnam war brought about the cessation of these grants. Many of these centers are forced to treat fewer patients now than they did

in 1967, despite the fact that the number of people requiring such services to stay alive has increased since that time.

All this is to say that we are now taking care of only a small fraction of those suitable for artificial kidney treatment. The reasons: lack of funds, lack of centers for handling these patients, and a lack of trained physicians, nurses, and doctors to provide this type of treatment. In 1967, Dr. Benjamin T. Burton submitted a report to the Surgeon General, "Kidney Disease, Program Analysis," which warned that personnel is perhaps even more of a critical factor than facilities in expanding our capacity to deliver kidney disease treatment. Clearly, unless we begin now to provide for the training of personnel, we shall "bottleneck" our ability to handle kidney disease in the future, regardless of how many facilities we are able to provide.

In addition to treatment by dialysis, there is, of course, the possibility of kidney transplants. To date, kidney transplantation is the most frequently executed and successful example of organ grafting, both in the United States and the world. To a significant extent, transplantation owes its success to the fact that an effective mechanical substitute organ, the artificial kidney we have just discussed, is available to rehabilitate the patient before surgery, to assist the patient and the transplanted kidney thereafter, and, if needed, to maintain the patients' life should the organ be rejected. Even then it is often possible to have a second transplant operation. Thus, the complementary nature of the artificial kidney and transplants further argues for Federal support of systematic development in these areas.

Furthermore, increased work in kidney transplantation, which has the very significant advantage of a backup mechanism should the operation fail, would be very helpful to medical research in general. A special committee commissioned by President Johnson and headed by Dr. Carl W. Gottschalk, of the University of North Carolina Medical School, reported in September of 1967 that many immunological problems encountered in transplantation of kidneys are common to transplantation of other organs. Hence, increased emphasis on kidney transplantation and the expected attendant immunological achievements will hasten the time when transplantation of other organs will be feasible.

The present situation is intolerable. People are dying needlessly. Medical personnel are being forced to make agonizing decisions concerning patient selection for the scarce existing facilities. Those unable to pay almost surely will not receive treatment. Tragically, most patients suitable for either dialysis or transplant are within the 15 to 54 age group.

Unlike most other chronic diseases, kidney diseases are particularly prone to bring death to patients in the middle and most productive years of their life. Thus the social and economic impact of this disease is way out of proportion to what these grim statistics we have been reciting would at first seem to indicate. For instance, a report to the Department of Health, Education, and Welfare in May of last year indicated that between July 1964, and June 1965, kidney diseases were responsible for the death of almost 60,000 people. In this same period, close to 8 million people suffered from kidney diseases and from diseases related to the kidney. These patients experienced approximately 140 million days of restricted activity, 64 million days of

bed disability, and almost 16 million lost workdays. The cost of these illnesses amounted to $1,210 million, making kidney disease the fifth most costly in the Nation. Further, it is estimated that some 3,300,000 people have an unrecognized and undiagnosed infection of the kidneys.

At last, we are ready to implement a potentially meaningful attack on this killer. But we have no cause to be overly optimistic at this point. The bill before this committee would set a maximum of $15 million to be spent in fiscal 1971 on kidney disease. I can only urge in the strongest terms possible that this full amount be in fact used for this purpose. Hearings before the subcommittee of the Committee on Appropriations last session brought out the sad fact that a fully effective attack on kidney disease would require $300 million in addition to needed increases in medical personnel. Authorization of a maximum amount of $15 million for kidney disease, with no guarantee that any amount will be so used, is a step in the right direction to be sure, but it is only a step. Increased amounts are needed now and in the future to deliver the services our research has made possible. We need to make greater efforts in the field of public health, for kidney and other major diseases, before we will have provided Americans with their first and most important right: the right to life.

STATEMENT OF HON. HENRY M. JACKSON, A U.S. SENATOR FROM THE STATE OF WASHINGTON

Mr. Chairman, it is a distinct honor to appear before your committee. Thank you for extending the courtesy to testify. I wish to direct my remarks particularly to the kidney disease portions of S. 3355.

As you know, I have been a longtime advocate of the need to forge an aggresive attack on our national kidney disease problem. In 1967, I proposed specific kidney disease legislation through S. 2675. In 1968, I proposed the "Artificial Organ, Transplantation, and Technological Development Act of 1968" through S. 2882. I reintroduced these provisions in 1969 in S. 88. Mr. Chairman, we have permitted estimates on the high cost of terminal kidney disease treatment to create myths which have paralyzed our ability to act coolly and sanely. As a result, we are condemning thousands of kidney disease patients to die needlessly each year, when the lifesaving therapies of hemodialysis and kidney transplantation can be made availble.

I represent the State in which the Quinton-Scribner shunt was developed, and the techniques of chronic hemodialysis were perfected. At the Seattle Artificial Kidney Center, we were the first to pioneer the provision of kidney dialysis on a continuing basis. We were the first to show that hemodialysis could be performed on a medically acceptable basis in the patient's home. We have been among the vanguard of the pioneers of kidney organ transplantation, and who are lighting the way for the development of other human organ grafts.

Our experience is that we can reduce the costs of treatment of end-stage kidney dialysis by training patients to carry it out in their homes or by performing kidney transplants. We find that as we continue to improve our techniques, costs can be pushed down. Additionally, the termination of Federal support for the Seattle kidney

activities forced them to seek other support sources. There are other sources, Mr. Chairman, and they urgently need development and organization. In the State of Washington, two major sources, beyond the patient's personal resources, are the vocational rehabilitation program and State appropriations to the department of health which covers costs not borne from other available sources.

I heartily endorse the inclusion of kidney disease programs in the regional medical programs which will be extended by S. 3355. Physicians who have carried forward the development of kidney dialysis and transplantation tell me that the major focus should be on transplantation, and that this is a "natural" for regional and multiregional development. This is because there must be a large pool of organ recipients in order to have a good statistical base—large numbers of recipients and donated organs—in order to improve the opportunity for transplanting the best organ for the particular patient. The recipient patient pool needs dialysis to be kept alive until a well matched organ becomes available, and to be maintained until the grafted organ functions well. There is emerging in the kidney disease area a need for regional and superregional organization of facilities.

Regionalization of health services across the country, such as is being developed through the regional medical programs service, is an obvious mechanism through which to meet these needs. Mr. Chairman, I will enthusiastically support S. 3355 when it comes before the Senate.

STATEMENT OF HON. JOSEPH M. MONTOYA, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Mr. Chairman, I am pleased to have this opportunity to present my views before this subcommittee in support of S. 3355, the Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970.

It has become obvious that we must do more to conquer the leading diseases in this country. As you well know, heart disease is the Nation's No. 1 killer and cancer is in second place. Together with strokes and kidney disease, these diseases account for more than 70 percent of all deaths in this country each year—over a million deaths last year alone.

These are very unpleasant statistics and it is heartening to know that in recent years great strides have been made in the quality of care available for those suffering from these diseases. New diagnostic and treatment techniques are being used, of which the heart transplant, which receives all the publicity, is just one example. Methods of prevention are being constantly studied and developed. Research laboratories and university medical centers have developed great new capabilities in the care of these diseases, and the patient who is able to obtain such care is a fortunate person.

Regrettably, however, not every patient suffering from one of these killers lives in an area with access to one of these large, highly skilled medical centers. If a person who does not live close to one of these centers has a heart attack, the chances are that his doctor may not have the latest information on care of the heart patient or his hospital may not have the necessary equipment and expertise in order to treat him in time to save his life. If such a patient suffers a stroke, it may be

that the proper management procedures are not known and practiced by the physicians, nurses, and therapists available to him. It may even be that there are no therapists available at all.

Most physicians manage to keep abreast of the latest medical and scientific knowledge. Many of our smaller hospitals have started to investigate their needs for the latest and finest in lifesaving equipment. Some have installed it and have found and trained personnel to operate it and are doing an excellent job of utilizing the latest and best techniques in their programs of care. It is more generally the case, however, that there is less chance that the patient who is farther removed from the larger medical center will get the same quality of care as he would receive in such a center.

It was this problem, as it relates to heart disease, cancer, stroke, and related diseases, that we in Congress directed ourselves to when, in 1965, we enacted Public Law 89–239, to create the regional medical programs, and when, in 1968, we voted to continue the program for an additional 2 years through the current fiscal year. In the words of former Surgeon General Dr. William H. Stewart, the purpose of the regional medical programs is "* * * to influence the present arrangements for health services in a manner that will permit the best in modern medical care for heart disease, cancer, stroke, and related diseases to be available to all." The focus of this program is on the patient.

In order to accomplish the purposes of this program, thus far 55 regional medical programs have been awarded planning grants to develop operational proposals through surveys of needs and resources, feasibility studies, and organization and staffing. In addition, 44 of these programs have received operational grants to improve patient care through research, continuing education, training, and demonstration projects, to develop better methods for the exchange of information among medical schools, medical centers, community hopsitals, practicing physicians, and other health institutions, organizations and personnel, and to continue to develop new and expanded plans for further improvement of patient care.

Some of the programs cover an area the size of a large city plus a few surrounding counties. Other programs cover an entire State or a group of several States. The concept of "regional co-operative arrangements" created by the original act recognized the geographical and societal diversities within the United States and utilized local initiative to make the program work. The act established a system of grants to enable representatives of local health resources to work together to improve patient care for heart disease, cancer, stroke, and related diseases at the local level.

The program we created in 1965 is showing some results. Thousands of persons have been involved in the intensive planning work that has gone on since the program began. Both the providers of health care and the consumers as well have participated in the many planning sessions that have gone on within each region into the development of the operational projects, the feasibility studies, and new proposals being considered.

The hard work they have done is beginning to bear fruit. The new projects and feasibility studies are bringing to the practicing physician and other providers of health care services valuable information

about the latest and finest medical and scientific technology in a manner that will enable them to upgrade the care of patients throughout each region. The task of forming truly regional cooperative arrangements that will be able to deliver the finest in health care services to every patient, no matter where he is in every region, is continuing. Additional communities, institutions, voluntary health agencies, and providers of health care services in each region are becoming involved in the function of identifying the needs of communities and areas and of devising solutions to those needs.

We in Congress need to support these continuing efforts. For this reason, I am proud to count myself as a cosponsor of S. 3355 to extend and amend title IX of the Public Health Service Act, the Heart Disease, Cancer, and Stroke program. The bill will not only extend the existing program relating to education, research, training, and demonstrations for an additional 5 years, but it will also add certain important improvements that will make the program's effectiveness even stronger.

I feel one important feature of S. 3355 is its new and separate grant program to give regional medical programs a chance to develop training programs to meet national demands for certain types of critical medical personnel and manpower. It does no good to develop new knowledge and technology if we do not have the personnel who can use it for the benefit of the patient. This new provision will allow for the training of such personnel when needs arise.

Another significant provision of the bill which I would like to point out is its broadened attack on kidney disease, specifically, and on all "other major diseases and conditions." Kidney disease is the fourth ranking cause of death in the United States, and it affects nearly 8 million persons in the country. We hear too many stories of persons being diagnosed with serious kidney disease whose lives could be saved and sustained with the application of proven treatment and technology but who instead face uncertain futures because we simply do not have enough treatment facilities and services available. This should not be the case, and it need not be if the effort envisioned in S. 3355 is put to the problem.

We have done a great deal toward conquering the leading killers in our Nation, but we can and must do more. For this reason, I strongly support the enactment of S. 3355, the Heart Disease, Cancer, Stroke, and Kidney Disease Amendments of 1970, and I hope this subcommittee will give favorable consideration to the bill as soon as possible.

Thank you.

Senator EAGLETON. According to our list, that completes the witnesses scheduled for today.

At this point I order printed all statements of those unable to appear at the hearings, and all other material pertinent to the record.

(The information follows:)

PREPARED STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION ON EXTENSION OF REGIONAL MEDICAL PROGRAMS

THE AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association is a federation of State optometric associations and societies representing just over 15,000 of the 17,000 optometrists engaged in practice in fifty States and the District of Columbia.

OPTOMETRY'S POSITION

As one of the five fully accredited disciplines comprising the Nation's primary health care team, optometry supports the laudable goal of renewing legislative authority for the Regional Medical Programs, which hold great potential for making major contributions to research, provision of highly specialized equipment and programing in the areas of the major "killer" diseases.

However, the American Optometric Association strongly opposes domination of the existing Comprehensive Health Planning program by the Regional Medical Programs, as proposed in the Administration's bill S. 3443, introduced by Senator Jacob Javits.

DESIRABILITY OF RESTRICTING SCOPE TO "KILLER DISEASES"

With reference to S. 3355, the American Optometric Association believes that adoption of the phrase "and other major diseases and conditions, and for other purposes" broadens the scope of Regional Medical Programs far beyond the desirable parameters set forth by the Congress when the legislation was originally enacted.

The reasons for our objection to this language are several. Generally, the phrase "and other major diseases and conditions" could lead to unnecessary overlapping of Regional Medical Programs with programs and projects already initiated by State and Area-wide planning and service agencies under the Comprehensive Health Planning and Services Act (Partnerships for Health), thus causing needless duplication and unwarranted expense to the Federal government.

The Comprehensive Health program, enacted in 1966, is only now beginning to function effectively, and is utilizing the combined knowledge and skills of professionals from all recognized health care fields. The Regional Medical Program does not utilize all available manpower and resources, such as those offered by the independent health profession of optometry.

A strong possibility also exists that inclusion of the phrase "other major diseases and conditions" could divert substantial sums of financial support from the vitally important areas of research and services provided for in relation to the specific killer diseases enumerated in the legislation.

Retention of such a broad definition could change the emphasis of Regional Medical Programs to the extent that RMP parallels the scope of activities encompassed by the Comprehensive Health Planning mechanism. Comprehensive Health is a system which concentrates on local, State and area needs, and which by its nature pinpoints those health problems perculiar to a specific geographic area. Based on the planning achieved under the Comprehensive Health program, local, state and area units then proceed to obtain the Federal financial assistance and services required in accordance with the priorities established. There is no justification for promoting and encouraging the overlapping of these two progams, when such overlapping would impair the integrity and definitive areas of responsibility of both the Comprehensive Health and Regional Medical programs. Such an approach does not, however, preclude the possibility of cooperative efforts between the two systems in those situations where cooperation will obviously result in more productive returns for the tax dollars invested.

RECOMMENDATIONS

The American Optometric Association urges deletion of the phrase "and other major diseases and conditions" in the short title of S. 3355, where it appears again at the end of line 6 and on line 7, page 2 of the bill under Sec. 2(a) section 900 (a) (3) and wherever else it may appear in the proposed legislation.

The American Optometric Association urges that the Committee retain the language spelling out specific areas of research and services authorized by the Regional Medical Programs legislation. This will ensure that appropriations for Regional Medical Programs will in fact be concentrated on finding solutions to the problems presented by the "killer diseases" rather than having that effort diffused by authorization to move into areas of activity more effectively and economically handled by ongoing Comprehensive Health Planning and Services programs.

Only in this way, we believe, can both programs develop their operational structures to a level of maximum efficiency.

CONCLUSION

The American Optometric Association appreciates this opportunity to place its views on record with the Committee, and will be pleased to cooperate in supplying any additional information the Committee may find helpful.

PREPARED STATEMENT OF IVAN F. DUFF, M.D., PROFESSOR OF MEDICINE AT THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

I am Ivan Duff, a Professor of Medicine at The University of Michigan Medical School. As Director of the Nation's pilot Regional Medical Arthritis Control Program, located in Michigan, I greatly appreciate the opportunity to state why the Congress and indeed all citizens have a vital interest in and support of S. 3355—the Heart Disease, Stroke, Cancer and Kidney Disease Amendments of 1970 which extends title IX of the Public Health Service Act.

I am testifying to stress that:

Since the Regional Medical Programs administration has acquired the responsibility for the programs of the National Center for Chronic Disease Control, it must be given authority to support programs in arthritis.

I would stress that Arthritis should be specifically mentioned in the title of S. 3355 since it is the Nation's other leading chronic disease.

If specific listing of Arthritis cannot be achieved it is clear that the language of this amendment should specifically include appropriations for the Regional Arthritis Control Program in Michigan and for similar research and development projects in the delivery of health services in arthritis and related diseases as had been commenced by the National Center for Chronic Disease Control. These would be comparatively small investments in a big problem.

JUSTIFICATION FOR MAKING ARTHRITIS SUPPORTABLE UNDER THE BROADENED SCOPE OF THE REGIONAL MEDICAL PROGRAMS

A 1966 Public Health Service analysis (1) of health problems arising from arthritis stressed that 13 million Americans reported some form of arthritis or rheumatism. Of the various forms of joint disease, rheumatoid arthritis (from which an estimated 3.6 million Americans suffer) produces the most crippling and disability; disability is more prevalent in lower income groups. The National Health Interview Survey (1961–63) reported that 3.3 million arthritics are limited in their ability to work, keep house, or engage in scholastic activities, and 700,000 of these are entirely unable to perform their major activities. Ten percent of all arthritics are home-bound or unable to move about without assistance. Rheumatoid arthritis occurring among juveniles is a major problem as well. In America there are an estimated 200,000 arthritics less than 25 years of age. The problems facing the family of the affected child, in terms of long term disability and dependence, are staggering.

The disability attendant upon arthritis occurs frequently in the productive years, consequently loss in earnings is substantial due to (1) work loss, (2) lost home-making services, (3) and lost work days (about 12 million lost-work-days due to arthritis occur each year). Benefits paid to arthritics by Social Security, Welfare Administration, and the Veterans Administration are enormous and the direct medical costs for arthritis are estimated to exceed one billion dollars annually.

"Arthritis, it is conceded, is a rare cause of death; the relatively low death rate points up that arthritis is a health hazard. The arthritic does not die quickly because of his disease, but rather continues as a consumer in our society while losing his ability to produce. He becomes deformed, disabled, and dependent for a large portion of his life, producing psychologic and economic stresses on his family, his friends and the community at large." [1]

The health problems associated with arthritis have been summarized as follows: *Arthritis is the Nation's number one crippler. It costs the United States economy more than three and one-half billion dollars a year.* Among the chronic diseases arthritis is second only to heart disease in resultant activity limitations.

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[1] Program Analysis of Arthritis, September, 1966, Department of Health, Education, and Welfare, particularly pp. 4–23, 31–36, 47–49, 89.

While there is an urgent need for a greater source of basic research directed at a greater understanding of the causes of these diseases, there is at the same time a very real gap in the delivery of the best available therapeutic measures to the victims of these diseases.

Current information indicates that total disability and crippling from arthritis can be reduced by the intelligent application of contemporary forms of therapeutic management. These reductions will lead to increased productivity. *A 1967 Health, Education and Welfare study indicated that an Arthritis Control Program could save the United States Government 1.5 billion dollars in direct and indirect savings, through increasing the earning power of individuals—that each $1 spent in an all out program to attack arthritis could save the government $42 in terms of taxes generated and reduced health costs.*

In 1965 a Surgeon General's Workshop on Prevention of Disability from Arthritis recommended the demonstration concept as one of the methods of attacking arthritis. The principle objective of this concept emphasizes the prevention of disability from arthritis through (1) early diagnosis, (2) excellent treatment and (3) continuing care. Concomitant goals are professional education, clinical investigation, development of community resources and public education. The original recommendation included the establishment and support of nine centers for the prevention and/or control of crippling from arthritis. The initial centers were to be geographically distributed to provide one such center of excellence and training in each Public Health Service districts.

In 1968, the 90th Congress made an appropriation of $500,000 for a single demonstration program to study prevention of disability from arthritis through contracts with the National Center for Chronic Disease Control. On January 13, 1969 the Diabetes and Arthritis Control Program, Division of Chronic Disease Programs, announced the availability of these funds and invited applications for the Nation's first arthritis center.[2] After consideration of applications from over twenty medical centers throughout the United States, the Public Health Service announced on June 18, 1969, that The University of Michigan and Detroit's Henry Ford Hospital would collaborate and establish the new Public Health Service Arthritis Control Program. Contract HSM–110–69–417 (appropriation 7590323) was negotiated in the sum of $467,433 for the first year.[3] The program was activated on July 1, 1969.

This pilot Arthritis Control Program in Michigan can very appropriately be regarded as a long-term research and developmental project in the delivery of health services in arthritis and related diseases. Its principle objective is entirely in keeping with the language of this amendment, for it does indeed strive to see that arthritis shall secure high quality health care; futhermore it provides for an analysis of cost benefits in accordance with the concept that efficiency (of delivery of health services) may be done at a cost which bears a reasonable relationship to the benefits received.

In essence, this is a program to demonstrate that crippling from arthritis can be delayed or prevented by a method of delivery of medical care which provides for early diagnosis, comprehensive evaluation of the patient's total problem, efficient and knowledgeable use of today's treatment measures, and provision for continuing medical and social support. The working design of our program includes analysis of social and economic benefits, direct medical costs, as well as objective criteria for measuring physical benefit.

I would summarize our progress to date:

(1) In 8 months of operation we have demonstrated that the participation of many health related disciplines can be obtained in the formulation and operation of such a project. This program is the product of successful collaboration between physicians with an interest in arthritis and rehabilitation, physical and occupational therapists, public health nurses, social workers, behavioral scientists, specialists in research design, statistics, data retrieval, analysis of program direct costs and benefits and measurements of social costs.

(2) We have demonstrated that cooperation of patients can be obtained. Our contemplated goal at the end of five years was about 600 rheumatoid patients; since admission to the program of the first patient early in September, 1969, 60

[2] Correspondence DCDP: D&A, January 13, 1969, from Glen W. McDonald, M.D., Chief, Diabetes and Arthritis Control Program, Division of Chronic Disease Programs, Regional Medical Programs Services.

[3] Contract No. HSM–110–69–417 between the Regents of the University of Michigan and the Health Services and Mental Health Administration (Appropriation 7590323; Allotment 9–0860/00/k20/220; RPF No. HSM–110–D&A 5[9]).

eligible adults and children with rheumatoid arthritis have been entered into the study. In short, we have something to deliver and we are making delivery.

(3) We have demonstrated that such a program can be truly regional—two-thirds of the people in Michigan reside in the Detroit-Ann Arbor-Grand Rapids area. There is a real potential for expanding this to a state-wide program through the network of active patient service teaching clinics for physicians, now operative in 11 key locations throughout Michigan. The Michigan Arthritis Foundation by supporting these clinics in a total of $100,000 a year, implements the yield of the Regional Arthritis Control Program.

This program, vitally concerned with the delivery of medical services, carried with it the moral commitment for continued support. It was intended to be of 5 or more years duration. But, at this moment, I have no assurance of funding after July 1, 1970. Furthermore, broadening of the mandate of the Regional Medical Program is essential for its continuation in 1971.

PERTINENT LEGISLATIVE HISTORY

Review of the legislative history leading to the establishment and fate of this program is pertinent.[4] The Diabetes and Arthritis Control Program came into existence in 1961–1962, being set up under the Bureau of Community Health. Under the "Comprehensive Health Planing and Services Act" a National Center for Chronic Diseases was created, January 1, 1967, in a complete reorganization of the Public Health Service. In 1968, the Public Health Service again regrouped, with the Division of Chronic Diseases coming under the Regional Medical Programs Service under the National Center for Health Services Research and Development within the newly created Health Services and Mental Health Administration.

The merger of the Division of Chronic Diseases with the Regional Medical Programs Service raised a question as to whether or not arthritis is supportable under the original legislation which authorized Regional Medical Programs (6). We would like to have this specifically stated in the legislation under consideration today.

The jeopardy in which the program in Michigan had been placed was further apparent when, within 90 days after its activation, public announcement was made of the necessity to eliminate the activities of 5 of the 8 chronic disease programs during fiscal year 1970, including Diabetes and Arthritis and the Michigan Program. Paradoxically, the reduced appropriations made at the same time for medical research, were purportedly to emphasize delivery of health service!

In bill H.R. 13111 for 1970, the Senate committee, in opposition to the proposal of the Department to make a 4 million dollar reduction in chronic disease programs, including diabetes and arthritis, added this amount to maintain these programs at their previous operating level, these funds could not be used for any other purposes. Information is not available, as of this date, as to the fate of funds appropriated for chronic disease programs, including arthritis, in the HEW bill now under revision.

Dr. Stanley W. Olson, Director of Regional Medical Program Service[5] has assured us that the contract for support of the Arthritis Control Program in Michigan can be extended for one additional year *with no added funds*—"to buy the necessary time to find out whether the extended legislation, by removal of the categorical restrictions, may make arthritis a supportable disease under Regional Medical Programs".

In summary, we recommend:

Since the Regional Medical Programs administration has acquired the responsibility for the programs of the National Center for Chronic Disease Control, it must be given authority to support programs in arthritis.

We stress that Arthritis should be specifically mentioned in the title of S. 3355 since it is the Nation's other leading chronic disease.

If specific listing of Arthritis cannot be achieved it is clear that the language of this amendment should specifically include appropriations for the Regional Arthritis Control Program in Michigan and for similar research and development projects in the delivery of health services in arthritis and related diseases as

[4] Legislative history of Diabetes and Arthritis Control Program, American Law Division, Janice Glasser, Library of Congress, prepared for Senator Hart on December 22, 1969.

[5] Correspondence, October 9, November 17, December 9 and 15, 1969 from Stanley W. Olson, M.D., Director, Regional Medical Programs Service, Health Services and Mental Health Administration.

had been commenced by the National Center for Chronic Disease Control. These would be comparatively small investments in a big problem.

PREPARED STATEMENT OF DONALD C. FARMER, EXECUTIVE DIRECTOR, NASSAU HEART ASSOCIATION, MINEOLA, N.Y.

I have been employed as the Executive Director of the Nassau Heart Association since July of 1964. Before that, I was the Executive Director of a Chapter of the Massachusetts Heart Association from October, 1951 to July, 1964. Since March of 1965 to the present time, I have been serving also as the Administrative Coordinator of the Nassau County Coordinated Stroke Program. In the Nassau County Stroke Program, I have worked closely with the Stroke Section of the Heart Disease and Storke Control Program, a program of the Division of Chronic Disease of the United States Public Health Service.

Please be advised that the technical skill of personnel that have been mobilized at the Federal level to develop program models that can be tested for effectiveness is superior. A detailed testimony to support this statement can be provided by a comprehensive review of the Stroke program that has been planned and is currently being operated in Nassau County. We have been cooperating with the personnel of the Stroke Section of the Heart Disease and Stroke Control Program to provide a community laboratory to develop a model comprehensive stroke program.

Through the applied technical skill of federal personnel, we have pioneered in the first phase of this model program to establish patterns for an effective community stroke survey.

The second phase is now in operation in cooperation with other communities in the United States; namely, Alameda County, California, Chatham County, Georgia, Jefferson County, Alabama, Salt Lake Area, Utah and Washington County, Maryland. This phase of the program is entitled, "Collaborative Community Stroke Study." It should be pointed out that these initial efforts lead very naturally into other sequential phases of a totally planned program. This program will identify stroke problems and determine specific local community and/or national resources needed to attack these problems. It will evaluate the effect of action programs on a continuous basis and be able to change directions quickly to meet changing needs. And, ultimately, we should be able to operate primary stroke prevention programs.

All of this is possible because of the skilled professional personnel who have been mobilized in the Chronic Disease Program.

I do not object to reorganization of the Federal Government's Department of Health, Education and Welfare. I do not object to the action taken to make the Chronic Disease program a part of the Regional Medical Program. I do object, however, to the plan to phase out the Chronic Disease Program which will consequently destroy years of work spent in developing a core of very skilled and effective professional community health personnel. I say this from almost twenty years experience in a professional career with a voluntary health agency that has worked in close cooperation with government in health matters. It is my opinion that the Staggers Bill—H.R. 14284 which is also concerned with extension of the Regional Medical Program is more effective than the Yarborough Bill—S. 3355 in providing a separate and sustained position for Chronic Disease Programs within the total provisions of the Regional Medical Program.

I am, therefore, petitioning that special attention be given to including the necessary provisions for retaining the chronic disease program as a special division of the Regional Medical Program.

Finally, it seems inconsistent to palce a special emphasis on control of heart disease, cancer, stroke and related diseases by creating legislation for the Regional Medical Program and then take action to phase out the chronic disease program which is also concerned with control of heart disease, cancer, stroke and related diseases.

It is however, consistent to merge the two efforts but not to cut chronic disease funds and risk the loss of very skilled personnel that has been mobilized by the chronic disease program.

Additional and detailed information about the Nassau County Coordinated Stroke Program in relation to this subject is available if neded.

PREPARED STATEMENT OF EUGENE H. GUTHRIE, M.D., CHAIRMAN OF THE BOARD, AMERICAN ACADEMY OF COMPREHENSIVE HEALTH PLANNING, BALTIMORE, MD.

It was only at the last moment prior to the hearings of your Committee on legislation to extend the Regional Medical Programs that we learned the Administration intended to introduce a bill which included regional medical programs, comprehensive health planning and other programs.

The purpose of this statement is to speak to this combination legislation and to inform your Committee on the position of the American Academy of Comprehensive Health Planning in regard to it. We respectfully request that this letter be made a part of the hearing record.

The preoccupation of this bill with the amalgamation of one of the many complementary programs to comprehensive health planning, is hard for us to understand. Comprehensive health planning is working with regional medical programs already in almost every state and community around the country. This is, of course, only one of many Federal programs with which comprehensive health planning becomes involved in working arrangements. So far as we are concerned, there is nothing at this time that precludes an effective working relationship between these two programs in the current legislation. It does concern us, however, that to single out one of these programs for a special affiliation implies a singleness of purpose for comprehensive health planning which we do not believe was intended. In our opinion, it also prematurely sets a predetermined course of action for this program not warranted by experience to date. We do not believe that we have the evidence of any general trend or desire that the program should indeed be so singularly directed.

The purpose of Public Law 89–749, commonly referred to as the Partnership for Health Act, was and even at this late date still is, to establish the obviously necessary and important process of planning into our national, State and local "health industry," with a number of provisions to make this planning comprehensive, responsive to providers and consumers, concerned with public and private interests, along with many other objectives.

We are convinced that the need for the comprehensive health planning program is just as acute and important at this date as it was when the Partnership for Health Act was passed. We must continue in the development of this program to serve the highly important purposes for which it was intended. Any digression from this major thrust at this time would, we believe, jeopardize the great potential that this program offers.

It is our opinion that most of the provisions of this Bill can be accomplished through administrative means available at the present time or that can be constructed, and that there is no need for complicated new legislation at this late date. The many questions raised by the new legislation, for which there is little time to prepare adequate information and response, could jeopardize the entire program unnecessarily and without just cause.

In summary, it is our opinion that the most prudent course of action at this time would be to simply extend the current legislation which in our opinion is adequate to continue the development of this program. Such further needs as do exist in our opinion can be adequately handled by appropriate administrative measures. There are needs for additional funds at the State level to further implement the developing 314(a) agencies. Also there is an acute need for more funds to develop the very necessary areawide comprehensive health planning agencies authorized under Section 314(b). Thus, it is our hope that your Committee will extend legislation authorized under Public Law 89–749 and increase the authorizations for appropriations under Section 314 (a) and (b).

If we can offer any further information or be of assistance to your Committee in any way, please call upon us.

PREPARED STATEMENT OF ERNEST B. HOWARD, M.D., EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

We wish to advise you of the interest of the American Medical Association in two bills, presently before your Committee, which would affect important health programs including the Regional Medical Programs.

S. 3355 would extend the Regional Medical Programs, and among other things open up the programs to include all major diseases. On February 17, your Committee was presented with an Administration proposal which combines under one umbrella in the Department of Health, Education, and Welfare, Regional

Medical Programs, Comprehensive Health Planning and Public Health Services, and Health Facilities and Services, Research and Demonstration. Under this proposal, S. 3443, the Regional Medical Programs would be significantly changed.

As I feel sure you are aware, the American Medical Association has supported the RMP program, which is essentially educational in character. Physicians throughout the country have participated in the program's development. At its most recent meeting, the AMA House of Delegates formally affirmed "its support of the concept of Regional Medical Programs as enacted in P.L. 89-239" and urged the AMA membership "to participate at all levels in giving guidance to implementing Regional Medical Programs in line with the highest tradition of the private practice of medicine."

Because of the significance which we attach to the changes which the proposed legislation would make in Regional Medical Programs as well as in the other important health programs, we would like to review the bills carefully. Accordingly, we have asked the appropriate councils and committees of the American Medical Association to consider them.

I regret that because of the shortage of time we cannot offer to your Committee comments on the bills before you. However, we feel that to have proceeded in a more summary fashion in arriving at recommendations would not have properly discharged the responsibility which we feel toward these programs in behalf of the public and the profession.

We shall be pleased to forward to you our views after we have concluded our analysis. Thank you for this opportunity to submit these preliminary observations.

PREPARED STATEMENT OF BERWYN F. MATTISON, M.D., EXECUTIVE DIRECTOR, THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC., NEW YORK, N.Y.

This statement will present the views of the American Public Health Association on S. 3355, the bill which you introduced to extend the authority for Regional Medical Programs. I do not believe there is a need to qualify at length the interest of the APHA in legislation which affects the health potential of the American people to the degree Regional Medical Programs do. Suffice it to state that the over 25,000 members of the APHA are anxious that these programs be as beneficial to those recipients of care as is our concern with the several other Federal health support programs.

In 1968, when the present authority was being considered by the Congress, Dr. Lester Breslow, then President-Elect of the APHA, and testifying in its behalf, stated, "The effective organization and utilization of the (health) resources that we now have and the unique contribution of the (then) original cooperation arrangements are made possible by this program. The unique contributions are to extend the excellence of the medical centers out into the communities and to accelerate the progress that is being made."

The contribution to which Dr. Breslow referred in his testimony has in general been realized, at this juncture, probably in no less nor greater degree than might have been expected from such an ambitious undertaking. A candid and objective appraisal of developments to date would probably reveal that progress has varied from one portion of the country to another. Certainly, much remains to be accomplished in the application of present medical and technical knowledge in many areas. In some areas, the progress has been admirable within the budgetary constraints which have been obtained in the past few years.

In respect to the specific amendments proposed in S. 3355, we would make the following observations.

(a) We have reservations relative to the earmarking of specified amounts for certain disease entities as is proposed for kidney disease. No one could possibly contest the need for markedly increased funds for kidney disease research or for kidney dialysis facilities, but legislating the proportion of available funds for one disease does not appear to us a logical approach.

(b) We support the addition of both official agencies and planning agencies to the advisory groups authorized under Section 903(b)(4). We concur with your further proposed amendment to said Section of the PHS Act to include expertise on the financing of services and the requirement that the "—advisory group shall be sufficient in number to insure adequate community orientation." We believe the term "orientation" to be particularly appropriate.

(c) We are especially in support of the proposed amendment to Section 904(b) (Section 7 of your bill) whereby applications for RMP funds would be subject

to consideration by Section 314(b) agencies where such exist. May we suggest, however, that Section 7 of S. 3355 be expanded to include, where practicable, the Section 314(a) state health planning agencies. There are a number of instances where identical geographic areas are encompassed by both the 314(a) health planning agency and the RMP. Certainly in such instances there should be recognition in the Federal statute that cooperative arrangements are to be encouraged.

One further word in respect to the essentiality of better cooperative arrangements among and between health program efforts. As presently constituted under Federal law, the state and area wide health planning agencies are charged with the responsibility of a continuing review and evaluation of the total health effort within their area of jurisdiction. As with other Federal health support efforts there should be a tie between RMP's and the Comprehensive Health Planning agencies. There are in existence at this time a few excellent examples of truly joint efforts, examples of cross representations between Comprehensive Health Planning and Regional Medical Program advisory groups and administrative personnel, both of which have the same objective. Two states, Georgia and West Virginia and one local area, Memphis, Tennessee, have had particularly good results. Such examples should be emulated.

We are hopeful that these suggestions will be helpful to you and your Committee. If we can furnish further information, we would be pleased to be of service.

The American Public Health Association urges the approval of S. 3335 with the suggestions outlined above.

PREPARED STATEMENT OF SHERWIN L. MEMEL ON BEHALF OF FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman and Members of the Committee, I am Sherwin L. Memel, a Vice-President of the Federation of American Hospitals. The Federation of American Hospitals is the national association of proprietary (investor-owned) hospitals and speaks for approximately 500 hospital facilities through its members and affiliated State organizations.

THE INVESTOR-OWNED HOSPITALS

Our records reflect that there are approximately 1,000 acute-short-term proprietary hospitals in the United States. These facilities represent about 20 percent of the nation's non-governmental hospitals. However, in some areas of the country investor-owned facilities represent up to 100 percent of the hospitals. These hospitals have to a great extent served to prevent a health crisis by filling a gap in construction of hospitals in both those communities which were too poor to finance tax-exempt hospitals or in those towns which grew so rapidly that the area could not keep up with exploding populations.

Investor-owned proprietary hospitals throughout the United States provide emergency, maternity, pediatrics, and other specialized services, often without recouping the full cost of such services. They provide these services in recognition of the fact that they have an obligation to the community in which they are located.

Te term "proprietary" or "for profit" has been applied historically to hospitals which have been financed other than on a non-profit and governmental basis and where any net profits ensure to the benefit of the owners. I prefer to term these hospitals "investor owned hospitals", for in fact non-profit and governmental hospitals are proprietary in the sense that they are owned by the organizations that operate them and I believe the term "investor-owned" is more appropriate than "for-profit hospital" because the latter term implies an exclusive purpose of operation for profit, which is absolutely untrue for the vast majority of investor-owned hospitals in the United States.

The investor-owned hospitals of America as an integral part of the nation's health industry are ready with government and others to meet the challenges of the future.

During the past six months, the Federation of American Hospitals has adopted resolutions supporting experimentation with a negotiated rate for providers leading to reliable actuarial predictability of costs to the government and endorsing the concept of access for all of our people to quality health care under health insurance. We have appointed committees to study these proposals and recommend the means to carry out these goals. We are cooperating with other health organizations in these studies.

Mr. Chairman, the Federation of American Hospitals supports the extension of the Regional Medical Programs as proposed in S. 3355. Since the enactment of Public Law 89–239 in 1965, 55 Regional Medical Programs have been developed covering the entire United States.

The timing of this proposed extension is particularly critical because many of these programs are just now becoming operational. S. 3355 would provide for gradual increases in the authorizations for these programs to a high of $250 million in 1975. This long range commitment by the Congress would strengthen and reinforce the involvement of those segments of the health industry which have participated and are willing and able to participate in the program.

The present legislation places emphasis on supporting research, demonstrations, education and training programs concerned with Heart Disease, Cancer, Stroke and Related Diseases. These are the major killer diseases in America today, accounting for substantially more than one million deaths last year.

The Federation of American Hospitals supports the extension of the program to include Kidney Disease and "other major diseases and conditions." This subcommittee has heard testimony from leading physicians who have discussed their frustrations at the knowledge that proven treatment exists which could save thousands of lives, if made available to the many kidney patients, the majority of whom are in their young or middle years. Nine out of ten patients with chronic kidney disease in the United States today face death because of their lack of access—financial or otherwise—to an artificial kidney machine and kidney transplantations.

While kidney disease is presently included under the Regional Medical Programs as a "related disease", we believe it should be specifically mentioned in order to receive earmarked funds.

Mr. Chairman, the investor-owned hospitals have not been included in Regional Medical Programs, however S. 3355 authorizes the Secretary of H.E.W. "to contract for . . . programs, services and activities of substantial use to two or more regional medical programs . . . development, trial, or demonstration of methods for the control of Heart Disease, Cancer, Stroke, Kidney Disease, or other major disease and conditions"; . . . and for "the conduct of cooperative clinical field trials," among other objectives.

This contractual authority, supplementing the Secretary's grant authority, would apply to investor-owned hospitals and the Federation of American Hospitals endorses and welcomes this amendment. We must use all existing resources to achieve national goals in improving our health care delivery system and S. 3355 recognizes this principle in expanding the contractual authority of the Secretary.

Mr. Chairman, the Federation recognizes that the Subcommittee will also be considering S. 3443 which provides for a broader legislative package extending at the same time comprehensive health planning and health services research and development. In addition, S. 3443 creates a single advisory council for these programs. The Federation of American Hospitals does not take a policy position on these proposals at this time except to state our concern that the specific objectives of the Regional Medical Programs retain their independence. We would certainly be opposed to a merging of priorities which tended to subordinate the Regional Medical Programs to a position of lesser importance. In the same vein, we note that the creation of a single advisory council for three programs may weaken the ability of council members to deal constructively and effectively with programs just reaching the operational level.

Discussing the proposed single advisory council in his testimony before the Subcommittee of February 17, 1970, Assistant Secretary of H.E.W., Dr. Roger O. Egeberg, stated:

"The proposed National Advisory Council is specifically designated to advise the Secretary of H.E.W. on the coordination of these programs with other Federal and federally-assisted health programs, giving particular attention to the relationship between the organization and delivery of health services and the financing of such services."

Secretary Egeberg's remarks could be interpreted as envisioning a single National Advisory Council concerned with restructuring the nation's health care delivery system. Without commenting on the respective merits or drawbacks of such a broad mandate, we do suggest that any such effort be studied and explored in great depth prior to adoption.

Mr. Chairman, the Federation of American Hospitals expresses its gratitude to the Committee for this opportunity to present the investor-owned hospitals' views on this most important subject.

PREPARED STATEMENT OF JAMES E. PERKINS, M.D., MANAGING DIRECTOR, NATIONAL TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, NEW YORK, N.Y.

The National Tuberculosis & Respiratory Disease Association wishes to record its support for S. 3355, continuation of authority for Regional Medical Programs. It is essential that this Federal program be allowed to reach its potential in improving the quality of health care in the United States.

Our organization is especially eager that Regional Medical Programs continue their operations because they offer the most viable method of demonstrating high quality treatment for chronic respiratory disease patients. In 1967, the Congressional Appropriations Committee requested that the problems of emphysema and chronic bronchitis be given attention in the operations of RMPs because of the increasing toll of disability and death from these diseases.

Today there are more than a dozen projects financed through RMPs which are specifically concerned with improving services for chronic respiratory disease patients. One of these in your own state, under the direction of Baylor University, covers 12 counties which are benefitting from a broad professional and public education program. Several major hospitals, including a Veterans Administration hospital, a local tuberculosis and respiratory disease association and the state health department, are all involved and contributing resources.

There are also about a dozen RMP projects concerned with pediatric pulmonary problems. These are important because the incidence of childhood respiratory disease may be related to the development of chronic obstructive lung disease in adult life.

In short, the RMPs offer the only mechanism currently available for the types of continuing education programs so needed by community physicians and health practitioners in the field of pulmonary disorders. We attach a list of the respiratory disease projects funded by RMPs as of a recent date.

Although the total of these projects is small, it represents a very important beginning because the need is so acute. There is a great deal of interest on the part of board members of our affiliates throughout the country and members of State Thoracic Societies (the medical sections of our associations) in seeing that these projects are expanded.

It is essential that we improve our resources in the field of pulmonary medicine as soon as possible. Therefore we are in favor of the legislative intent embodied in Section 910(a)(4) to expand opportunities for training. In fact, the needs in pulmonary disease training are so urgent that we request your consideration of adding the words "pulmonary disease" to the title of the Act under Section 900(a)(3).

In addition to physicians trained in pulmonary disease, paramedical personnel are also needed to assist in diagnosing, treating and rehabilitating chronic respiratory disease patients. These include clinical nurse specialists in respiratory disease, pulmonary function technicians, and inhalation therapists. The supply of trained personnel is distressingly small and qualifications of many who are working in the field are unsatisfactory. These inadequacies are directly translated into substandard care of patients.

The problem of quality of care is one to which this organization especially addresses itself. Examples of substandard care which we frequently see in tuberculosis control include the patient who is given only one drug when multiple drugs are needed or in whom drug treatment is discontinued before the disease process is arrested. This type of medical treatment not only has disastrous consequences for the patient's life but favors the spread of a communicable disease in the community.

The emphysema patient is often seen in a terminal stage because his disease has never been recognized until he is in a moribund condition. At that point he may go to a hospital where the medical know-how to save his life is not present. The patient who may have come to respiratory collapse following an operation or an accident is in the same life-threatening position.

We are also glad to note under Section 910, provision for development and demonstration of control methods, and also for the collection of epidemiological data—imprtant functions which have been performed by the chronic disease control programs and which we think should be continued.

Addition of the contract mechanism under Section 901 will enable the Division of RMP to provide some national direction to the huge Federal program they are funding—a serious lack in the past, in our opinion. Many areas of activities especially need central direction in the chronic respiratory disease field which can be provided by the Division, such as organizing collaborative studies between clinical investigators to evaluate diagnostic and therapeutic methods and contracting for development and evaluation of instruments and devices to be used in diagnosis and treatment.

All these changes will help reverse the effects of what seems to be the Administration's wish to de-emphasize categorical disease activities within the Federal health establishment. In our opinion, this trend poses a considerable threat to the quality of diagnosis and treatment provided in health care delivery systems. The examples of substandard care given to respiratory disease patients cited above illustrate that health care systems, if they are to be of high quality, need the skills of practitioners trained to handle specific diseases.

We believe that S. 3355 improves the present title by adding prevention and rehabilitation. Rehabilitation of chronic respiratory disease patients is extremely important and has been demonstrated to be effective. Unfortunately, such services are very limited in quality and amount. In recent years, emphysema has been the second leading diagnosis for which Social Security benefits are awarded to workers who retire prematurely due to disability. In view of increasing population and environmental hazards, there appears to be little hope of a marked diminution in the incidence of these diseases in the immediate future.

In reference to revision of Section 904(b) to provide for cosideration of an RMP application by the 314(b) planning agency, we are concerned that administrative complexities in the Comprehensive Health Planning Program are tending to delay initiation of worthwhile projects. To involve 314(b) agencies in RMP review may complicate progress in the latter program. However, a larger question is involved, in our opinion, as to whether it is advisable for a review body of one program to consider applications of the other when the objectives of the two programs are essentially dissimilar.

Grants under Section 314 are for financing of community health programs—314(d) formula funds for ongoing public health services and 314(e) funds primarily for demonstrations and innovative programs. The Regional Medical Program, however, was intended to facilitate bringing developments in medical research more quickly to the community practitioner in order that he could apply these in his practice and thus upgrade the quality of care being given to his individual patient. RMPs were not intended to be directly involved with the organization of the health care system.

To us, the stength of the RMPs lies in their ability to catalyze the skills and talents existent in medical schools through support of projects of interest to the various medical disciplines represented in these schools. In other words, the lung specialist is interested in promoting and working in projects which can utilize and help develop and promote resources in the field of pulmonary disease. To require review by the 314(b) agency may be a negative influence on the future acceptance of this program by medical schools.

Secondly, it has occurred to us that such review might pose an administrative problem. Some RMPs cross state lines and it is possible that there may be no areawide 314(b) planning agency in one part of the RMP region. The agency that does exist would have relevance only to the area in which it is situated.

We would appreciate our support of S. 3355 being made a part of the record of the hearings on the legislation.

FUNDED RMP PROJECTS BY SPECIFIED PROGRAM PERIOD

		Total funds available		
		1967	1968	1969
ADULT PULMONARY				
Intermountain	Education program in respiratory therapy for M.D.'s and nurses.	$25,300	$43,800	$8,100
Washington/Alaska	Cardio-pulmonary technician training, Spokane Community College.	----------	44,300	18,700
	Community exercise rehabilitation program, cardio-pulmonary.	----------	----------	39,600
Wisconsin	Pilot demonstration pulmonary thrombo-embolism, Marshfield Clinic, Marshfield.	88,700	65,900	64,200
Colorado/Wyoming	Training and applied research for intensive and rehabilitative respiratory care (emphysema and chronic bronchitis), University of Colorado Medical Center.	----------	----------	140,500
Metropolitan District of Columbia.	Comprehensive pulmonary training for M.D.'s, nurses, technologists, Georgetown University.	----------	----------	75,700
Western New York	Chronic respiratory disease program (Millard Fillmore Hospital), screening, referral, training.	----------	----------	516,600
Memphis	Regional program for emphysema and coronary pulmonale. Outpatient facility, City of Memphis Hospital.	----------	77,100	87,800
Texas	Organization and strengthening of community hospitals: inhalation therapy, patient care program.	----------	59,100	----------
	Areawide total respiratory care—12 counties (screened for TB and respiratory disease) teaching and training centers—Jefferson Davis Hospital, VA and Methodist through San Jacinto TB and Respiratory Disease Association and State Health Department.	----------	219,200	----------
Maryland	Establish model ambulatory pulmonary service, Maryland General Hospital, Baltimore.	----------	----------	90,000
Mississippi	Training in diagnosis and treatment, chronic pulmonary disease, University of Mississippi (formerly earmarked planning) now operational.	----------	(142,700)	265,200
Oklahoma	Regionwide emphysema program teaching demonstration unit, University of Oklahoma M.C.	----------	----------	185,600
New Mexico (02 year)	Cardio-pulmonary evaluation laboratory (St. Vincent's Hospital, Santa Fe).	----------	15,000	24,000
California (supplemental)	Breathmobile, chronic respiratory disease (currently being funded).	----------	----------	135,000
Northwest Ohio (Toledo)	Improve respiratory care for patients in extended care facilities—rehabilitation; continued education in chronic pulmonary disease.	----------	----------	130,600
PEDIATRIC PULMONARY				
Washington/Alaska	Cystic fibrosis—early detection and improved patient care children's Orthopedic Hospital and Medical Center, Seattle.	----------	54,800	52,600
California	Pediatric pulmonary (Irvine) Demonstration Center, Orange C.M.C. and Children's Hospital (Irvine).	----------	272,600	[1] 244,100
Colorado/Wyoming	Expand facilities for pediatric pulmonary program, University of Colorado Medical Center (formerly earmarked planning).	----------	(49,600)	71,000
Hawaii	Pediatric pulmonary program Kauikeolani Children's Hospital (treatment, research, early detection and referral).	----------	----------	210,900
Georgia	Pediatric chronic pulmonary disease center, expand respiratory disease center, department of pediatrics.	----------	156,600	209,400
New Mexico	Establish pediatric pulmonary center Lovelace Clinic, Albuquerque.	----------	59,600	121,200
Greater Delaware Valley	Regional chronic pediatric pulmonary program, Philadelphia hospitals (Hahnemann, Children's, St. Christophers).	----------	----------	247,500
Metropolitan New York City (earmarked planning).	Pediatric Pulmonary Disease Center (extend cystic fibrosis center at Babies Hospital Columbia University, New York City into a pediatric pulmonary disease center).	----------	255,300	[2]

[1] Estimate.
[2] 02 year cont. in rev. process.

Note: Updated as of Sept 30, 1969, Office of Health Data DRMP.
Source: Office of Health Data, DRMP.

PREPARED STATEMENT OF RICHARD H. SCHLESINGER, EXECUTIVE VICE PRESIDENT, COMMUNITY HEALTH INFORMATION & PLANNING SERVICE, INC., (CHIPS), SYRACUSE, N.Y.

I am submitting my statement with regard to S. 3443, "The Health Services Improvement Act of 1970," introduced before your Committee by Senator Javits on February 16. I have not yet been able to obtain a copy of the bill to study in detail. However, being cognizant of your deadline for submission of comments, I am assuming that my attendance at Dr. Egeberg's briefing session on February 16, plus my perusal of Senator Javits' introductory comments and Dr. Egeberg's testimony before your Committee on February 17, have given me a sufficient grasp of the bill's content.

It is my impression that S. 3443, as submitted, takes several significant steps to coordinate and improve health planning activities which are currently underway at state and regional levels. Indeed, the proposed legislation, as I understand its current wording, has much to merit its support. However, I am left with a gnawing sense of disquietude after reading both Senator Javits and Dr. Egeberg's statements, an uneasiness created in part by what is *not* said in those comments and in part by the apparent underlying philosophy which may well govern the interpretation and implementation of this legislation (assuming it passes into law).

With respect to what is not said, I am particularly concerned that in the Javits and Egeberg comments I can find only one meager reference to concern about the health aspect of environmental problems. Indeed, I understand that the legislation itself contains only fleeting mention of this subject in the Preamble. One of the strengths of the original comprehensive health planning legislation and its implementing regulations was the emphasis on an ecologic perspective in health planning which saw the health care needs of man in the necessary framework of the environment in which he lives. There are many of us around the country who have been struggling with the problem of how to bring into effective focus the health aspects of the myriad environmental problems which this country faces today. I think it would be a serious error to deflect that growing concern at this juncture. As an item in point, I am enclosing a report of our Subcommittee on Goals and Priorities which recommends as a long-range goal for our developing regional comprehensive health planning agency (ALPHA) the "development of an environment which contributes positively to health," and suggests that attention to environmental matters should be a top priority.

I read with considerable concern Dr. Egeberg's statement that "under a more complicated and dynamic approach an areawide CHP agency could be given community responsibility for structuring the local health care system, including considerable influence over programs and capital funding decisions." This language is, of course, subject to differing interpretations, but in view of the apparent overall thrust of the proposed legislation, I believe I detect a strategy about which I have reservations. The legislation appears to me to provide for a centrally-directed re-orientation of the comprehensive health planning program, thus opening the health planning process to the risk that that process, as we have been trying to initiate it in our communities, may be transformed. Precisely because we are dealing with a pluralistic health world in which a number of accommodations—especially between public and private spheres—must be made, it is imperative that we have provisions for a planning process in which all of the parties at interest can participate in an atmosphere which will promote development of health services through a political process which is able to make use of appropriate trade-offs and compromises. What the proposed legislation appears to suggest is that the role of the comprehensive health planning agency is to be shifted to one of a "change agent" directed toward a federally predetermined goal—namely, development of a system for primary health care. Obviously, I would not quarrel with the goal per se. My concern stems from my impression that the comprehensive health planning agencies may be asked to accept this goal as their sole focus, and perhaps even worse, to accept certain changes in their methods of operation which may in time give them such statutory authority that the planning process itself will be bypassed to a large extent. In essence, the end result might then be that the comprehensive health planning agencies, which at this moment in time are largely voluntary in nature, would become primarily extensions of government.

Admittedly, the proposed legislation does not assure these dire consequences as its end result. However, it does seem to me that the potential for such results is

very real, and that the implications of such changes deserve the most careful consideration and evaluation.

One final comment. It seems to be entirely possible that most of the administration's stated goals can be accomplished within existing authority. This is certainly true with respect to coordination among the programs covered by the proposed legislation. Consequently, extensions of the existing legislation, such as those proposed in your own S. 3355 and in Congressman Rogers' H.R. 15895, remain an alternative which should receive deliberate review and assessment.

PREPARED STATEMENT OF BERTRAM L. TESMAN, M.D., STROKE COORDINATOR, UNIVERSITY OF CALIFORNIA, IRVINE, CALIF.

I have requested permission to testify before the Committee concerning Bill S. 3355. I understand witnesses have already been selected to give testimony, so I am writing this in the hope that my statement will be included in the hearing record.

As Stroke Coordinator of Area VIII of the California Regional Medical Programs I have the only on-going grant on stroke approved by the Division of Regional Medical Programs in California. Our program is a multi-disciplinary one and includes the training of physicians, nurses, speech pathologists, physical and occupational therapists and other health personnel in the care of the stroke patient throughout our entire Area. We believe it is unique in its attempt to upgrade the quality of care not only in one or several institutions, but in our entire community. By so doing we hope to make Area VIII a model for what can be done by total community effort and involvement.

As a practicing physician in the community, I fell obligated to write this letter because Division of Regional Medical Programs has given me and physicians in communities comparable to mine the opportunity to upgrade patient care in one category far beyond our greatest expectations. It is my feeling and belief that if programs like this are continued and expanded, more and more physicians will become involved and dedicate part of their busy time to trying to improve total patient care in their respective communities.

In our particular program much of the groundwork and foundation was accomplished by and with the complete cooperaton and consultation of the Stroke Division of the National Institutes of Chronic Diseases. Their knowledge, background and advice enabled us to attack our problem—a very complex one—both logically and scientifically. Obviously, as other programs develop, they must of necessity be included in the epidemiologic research necessary for the implementation of such projects. Unless provisions are made to spell out concisely their role and their relation with Regional Medical Programs, I believe future programs of this nature will not be as fruitful.

With these thoughts it is our hope that in the ultimate passage of Bill S. 3355 funds will be available to 1) maintain, 2) continue and 3) expand Regional Medical Programs, and 4) to make provisions to allow the excellent relationship between Regional Medical Programs and the National Institutes of Chronic Diseases to continue.

TELEGRAM FROM AMERICAN NURSES' ASSOCIATION IN SUPPORT OF S. 3355

NEW YORK, N.Y., *March 2, 1970.*

Senator RALPH YARBOROUGH,
Chairman, Senate Committee on Labor and Public Welfare,
Washington, D.C.:

The American Nurses' Association wishes to record its support for extension of regional medical programs provided for in S. 3355. Regional medical programs demonstrate that cooperative arrangements for medical care are successful; that members of health occupation can work as a team to provide high-quality care. The RMP show plans must be fashioned to meet area and population conditions utilizing available personnel and facilities. A variety of programs has developed. Some are carried out cooperatively with other agencies so that a broader spectrum of health services is provided.

With many programs just becoming operational, a period of time is needed to develop full potential. We support legislation extending the regional medical programs.

HILDEGARD E. PEPLSU, R.N. ED. D.,
Executive Director.

HEALTH SERVICES IMPROVEMENT ACT BUDGET ESTIMATES

	Fiscal year		
	1969 actual [1]	1970 estimate [2]	1971 estimate
Comprehensive health planning and services:			
314(a) State planning	$7,329	$10,371	$7,675
314(b) Areawide planning	6,174	7,700	10,200
314(c) Health planning training	3,186	4,125	4,125
Total planning	16,689	22,196	22,000
314(d) Formula grants	65,642	90,000	90,000
314(e) Project grants	75,851	82,782	[3] 109,500
Program direction	[1] 1,011	[4] 3,185	[4] 4,564
Total	159,193	208,163	226,064
Health services research and development:			
Grants and contracts	16,846	37,440	50,867
Direct operations	7,850	3,850	5,025
Program direction	1,390	1,212	1,511
Total	26,086	42,502	57,403
National health statistics:			
National vital and health statistics	6,860	8,633	9,358
State-Federal health statistics system			
Program direction	616	537	560
Total	7,476	9,170	9,918
Regional medical program:			
1. Regional medical programs:			
(a) Grants	72,365	73,500	79,500
(b) Direct operations	896	1,771	1,812
2. Technical assistance and disease control [5]		(18,287)	(13,168)
Regionalization activity of the RMP	2,038	1,795	1,805
3. Program direction including chronic disease control		(3,023)	
Program direction for regional medical programs	1,402	1,947	2,022
Total	78,701	79,013	85,139
Grand total	269,456	328,848	378,524

[1] Does not include budget item "Change in Selected Resources" for any of the programs.
[2] Program estimates are as they appear in the President's fiscal year 1971 budget and do not reflect final action on the fiscal year 1970 budget.
[3] Includes $30,000,000 transfer of funds and program responsibility from OEO.
[4] Total program direction of CHS.
[5] Includes chronic disease program.

Senator EAGLETON. This concludes the hearings.

(Whereupon, at 10:40 a.m. the subcommittee adjourned, subject to the call of the Chair.)

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